University of Wisconsin-Superior

INJURY REPORT *For Campus Safety & Risk Manager*

Name (Last, First MI)			**Date of Birth**	**MM**	**DD**	**YYYY**
			Month /Day/ Year			
Address (Complete permanent address)	**Date of Accident**	**MM**	**DD**	**YYYY**	**Time of Accident**	
	Month /Day/ Year					
	Medical treatment required?		*(Check if applicable)*			
	First Aid treatment only?		*(Check if applicable)*			

Exact location where accident took place (inside, outside, building name, room #, vehicle, etc.)

Describe the activity engaged in at the time of the accident (Explain in detail)

Nature of Injury or Illness

Have you been treated for a similar injury or condition in the past? Yes____ No____ (Check as applicable)

If ***Yes***, Dates of treatment, Name of Doctor, Hospital or Clinic providing treatment.

Part of body injured (check ALL that apply, and choose appropriate side and/or number 1-5)(Thumb=Finger 1, Great Toe=Toe 1)

	Abdomen		Hip L R		Shoulder L R		Mouth
	Back		Leg L R		Elbow L R		Chin
	Side L R		Ankle L R		Wrist L R		Ear L R
	Head		Foot L R		Hand L R		Nose
	Neck		Toe (1-5)		Finger (1-5)		Internal Organ(s)

Witnesses: NAME	**Address**	**Phone Number**

Report Date	**MM**	**DD**	**YYYY**	**Work Phone**	**Home Phone**	**Email**
Month /Day/ Year						

Injured Party

Print Name	**Sign**	**Date**

Report Number	**Reporting Officer**	**Date**

Fill out form then print out and sign/date bottom and bring it to the Public Safety Building.
Printed from web site.

CSD: 01/2016 INJURY REPORT FORM
CC: RISK MANAGER