RMS use only - OSHA Log Case No.

REPORT OF INCIDENT OR ACCIDENT

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

ATTENTION: This form contains information relating to an injured employee's health and must be used in a manner that protects the confidentiality of the injured to the extent possible while the information is being used for safety and health purposes. Reference: 8 CCR § 14300.29 (b)(6)-(10). This form must be completed within 24 hours of receiving information of an occupational or other University-related injury or illness to **Workers' Compensation Office, Riverfront Center 214, fax (916) 278-2641.**

IMPORTANT: Please go to http://www.csus.edu/aba/forms.html *Accident or Incident Report* to ensure that you are using the most current version of this form.

SECTION 1: UNIVERSITY RELATIONSHIP (SELECT ONLY ONE)

☐ Faculty ☐ Staff ☐ Student Employee ☐ Student Assistant Department: _____

☐ Student ☐ Auxiliary ☐ Contractor ☐ Visitor ☐ Volunteer Police Report Made ☐ YES ☐ NO

SECTION 2: INCIDENT TYPE (SELECT ONLY ONE)

☐ Injury ☐ Illness ☐ Other (Vehicle, Near Miss, Dangerous Condition, Exposure Incident)

SECTION 3: INVOLVED/INJURED'S INFORMATION

First Name: _____ Last Name: _____ M.I.: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Bargaining Unit: _____

☐ Male ☐ Female Date of Birth: _____ Date Hired Or N/A _____

SECTION 4: INCIDENT DETAILS

Note: If an accident occurred while driving on university business, you must also complete the Vehicle Accident Report form STD 270.

Date of Injury/Illness: _____ Time: AM/PM _____ Location: _____

DESCRIBE THE INCIDENT (STATE ONLY THE FACTS). Attach additional sheet of paper if necessary.

What was the person doing just prior to and at the time of the incident? What objects/conditions contributed to the incident?

Name(s) of Injured Persons & Witnesses: _____

If the incident resulted in an injury or illness, answer the following questions.

If this was a Sac State employee injury or illness, at what time did the employee begin their shift?: _____ ☐ a.m. ☐ p.m. ☐ N/A

a) Did the individual receive medical treatment in an emergency room? ☐ YES ☐ NO

b) Was the individual hospitalized overnight as an in-patient? ☐ YES ☐ NO

c) Did the individual receive medical treatment beyond basic first aid? ☐ YES ☐ NO

d) Did the individual immediately return to work? ☐ YES ☐ NO

e) Did the individual receive a modified work schedule due to the incident? ☐ YES ☐ NO

f) Did the injury or illness result in death? Date of Death: _____ ☐ YES ☐ NO

g) Date notified supervisor that injury occurred. _____

SECTION 5: HOSPITAL/CLINIC INFORMATION

Name of Clinic: _____

Address of Clinic: _____

Treating Physician: _____ Phone Number: _____

Original: Workers' Compensation Office, Riverfront Center 214, zip 6145

Revised April 2014

REPORT OF INCIDENT OR ACCIDENT

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

SECTION 6: INJURY/ILLNESS CATEGORIZATION

Section 6A: Part of Body Injured											
L	R		L	R		L	R		L	R	
☐	☐	Abdomen	☐	☐	Eye	☐	☐	Head	☐	☐	Shoulder
☐	☐	Ankle	☐	☐	Face	☐	☐	Internal	☐	☐	Teeth
☐	☐	Arm-Lower	☐	☐	Fingers	☐	☐	Knee	☐	☐	Thigh
☐	☐	Arm-Upper	☐	☐	Foot	☐	☐	Leg-Lower	☐	☐	Throat
☐	☐	Back-Lower	☐	☐	Forearm	☐	☐	Leg-Upper	☐	☐	Toes
☐	☐	Back-Upper	☐	☐	Genitals	☐	☐	Mouth	☐	☐	Torso
☐	☐	Ear	☐	☐	Groin	☐	☐	Neck	☐	☐	Wrist
☐	☐	Elbow	☐	☐	Hand	☐	☐	Nose	☐	☐	Other:

Section 6B: Nature of Injury			
☐ Abrasion	☐ Burn - Thermal	☐ Fracture - Break	☐ Repetitive Motion
☐ Amputation	☐ Burn - Electrical	☐ Hearing	☐ Splinter
☐ Bite/Sting	☐ Crushed	☐ Loss of Consciousness	☐ Sprain/Strain
☐ Blister	☐ Cut/Laceration	☐ Numbness	☐ Swelling
☐ Bruise/Contusion	☐ Dermatitis	☐ Pain	☐ Other (explain below):
☐ Burn - Chemical	☐ Dislocation	☐ Puncture	

Based upon my personal knowledge and/or information reasonably available to me, the above is true and correct.

SECTION 7: REPORT PREPARER'S INFORMATION

Print Name: _____ Title: _____ Phone: _____

Sign: _____ Prep. Date: _____

SECTION 8: ASSESSMENT AND CORRECTIVE ACTIONS

For Sac State employee injuries, Section 8 is to be completed by the employee's MPP or HEERA-designated supervisor.

Potential Cause of Incident	
Condition(s)	Action(s)
☐ Exposed electrical wiring	☐ Bypassed safety device
☐ Defective tools or equipment	☐ Equipment, failure to secure
☐ Hazardous arrangement	☐ Equipment, improper positioning
☐ Fall hazard	☐ Equipment, used inappropriate equipment
☐ Insufficient illumination	☐ Equipment, use of defective
☐ Improper PPE	☐ Failure to lockout or tagout
☐ Misplaced object	☐ Failure to use PPE
☐ Object in motion	☐ Horse-play
☐ Tripping or slipping hazard (slip, trip, or fall)	☐ Improper lifting techniques
☐ Hazardous atmosphere	☐ Operating equipment without training
☐ Other (explain):	☐ Other (explain):
☐ None	☐ None

What corrective actions have been taken to ensure that this incident (or hazardous condition) will not occur again?

Reviewer's Name and Title (Print)	Signature	Date

Original: Workers' Compensation Office, Riverfront Center 214, zip 6145

Revised April 2014