

REPORT OF INCIDENT OR ACCIDENT

This form must be submitted within 24 hours of receiving information of an incident to **Risk Management Services**.

SECTION 1: UNIVERSITY RELATIONSHIP (SELECT ONLY ONE)

☐ Faculty ☐ Staff ☐ Student Employee ☐ Student Assistant ☐ Student ☐ Auxiliary ☐ Contractor ☐ Visitor
☐ Volunteer ☐ Other _____ Department: _____

SECTION 2: INCIDENT TYPE

☐ Injury ☐ Illness ☐ Trip ☐ Vehicle ☐ Near Miss ☐ Dangerous Condition ☐ Exposure Incident ☐ ADA Condition
☐ Other _____ Police Report Made ☐ YES ☐ NO

SECTION 3: INVOLVED/INJURED'S INFORMATION

First Name: _____ Last Name: _____ M.I.: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

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 Incident: _____ Time: _____ AM/PM _____ Location: _____

Multiple persons involved ☐ YES ☐ NO

DESCRIBE THE INCIDENT (STATE ONLY THE FACTS).

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

Name(s) Witnesses: _____

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

- a) Describe injury and part of body affected. _____
- b) Did the individual receive first aid only? ☐ YES ☐ NO
- c) Did the individual receive medical treatment? ☐ YES ☐ NO
- d) Was the individual hospitalized? ☐ YES ☐ NO

Name of Clinic: _____ Physician: _____ Phone Number: _____

If this is a Sacramento State employee, what time did the employee begin their shift?: _____ ☐ a.m. ☐ p.m. ☐ N/A

- a) Supervisor: _____ Title: _____ Date/Time notified: _____
- b) Did the individual immediately return to work? ☐ YES ☐ NO

Preparer's Name and Title (Print)

Phone Number

Date

Submit electronically or fax copy to: (916) 278-2641