GENERIC INCIDENT FORM

NAME ___________________________________ CWID#________________________________________

DATE/TIME/OF INCIDENT _____________________________________

LOCATION OF INCIDENT ______________________________________

NOTE: STUDENT MUST GO TO STUDENT HEALTH SERVICES

DESCRIBE IN DETAIL THE INCIDENT. USE BACK IF NEEDED. INCLUDE what you were doing just before the incident; what happened; what was the injury, if any.

WHAT ACTION WAS TAKEN IMMEDIATELY AFTER THE INCIDENT? INCLUDE treatment site, names of physicians or other health care providers, if possible.

IF THE INCIDENT OCCURRED IN ANOTHER AGENCY, WAS AN INCIDENT REPORT MADE ON THEIR FORM?

_________ YES. If yes, please attach a copy to this form.

_________ NO

NAME, ADDRESS, AND PHONE NUMBER OF TWO PEOPLE WHO WITNESSED THIS INCIDENT:

1. 
2.

_________________________________ DATE ___________________________

SIGNATURE

FACULTY/SUPERVISOR SIGNATURE

____________________________ DATE ___________________________

REVISED 7/07; 10/13 Reviewed 6/08; 7/09