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.

_____ _____

SIGNATURE DATE

_____ _____

FACULTY/SUPERVISOR SIGNATURE DATE

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