

Case Number from the Log #	
WC – FAO - NI	

Use the tab key to move from one text field to the next.

HOPE COLLEGE ACCIDENT INJURY REPORT FORM

Please complete the following form as completely as possible and submit to Occupational Health and Fire Safety Office. Form must be completed within 24 hours of incident. Questions? Call Occupational Safety Office X7999 or Human Resources X7811.

Personnel Information					
Employee Name:					
Employee D.O.B.: (mm/dd/yyyy)					
Occupation:					
Employee's address:					
Employee Home Phone:					
Married (Yes) (No):					
Faculty/Staff/Student:					
Department:					
Name & Phone Number of Direct Supervisor.					

Incident Information:
(Date) and (Time) of Incident:
(Full Time, Part Time, Pool)
Location of Incident:
What was the employee doing just before the incident occurred?

Tell us how the injury/illness occurred:
Tell us the part of the body that was affected & how it was affected:
The white the abit to an exhabit and the bound the amount of the
Identify the object or substance that directly injured the employee:
▼
 What may have caused or contributed to the incident or illness?
 What action has been taken to prevent recurrence of this incident?
what action has been taken to prevent recurrence of this incident.
▼ E
 Did employee receive training on how to prevent this type of injury?

Injury Lost Time Information					
injury Lost Time Information					
Other than the day of the incident, will the employee lose time from work?					
Yes No Unknown					
If yes, what actual or approximate dates?					
Will the employee be on restricted or light duty?					
Yes No Unknown					
If yes, what actual or approximate dates?					
Type of Incident (Please check all that apply)					

	Type of Incident (Please check all that apply)								
Blood or Body Fluid Exposure (call Hope College Campus Safety to report exposure incident), (X7999)									
	Sharp or needle stick Splash								
	Contact with another person's blood or body fluid:							luid:	
	Name of exposed person.							l person.	
	Chemical Exposure Name of Chemical:								
	Slip/Trip /Fall		Lifting/moving material			Pushing/pulling object		Repetitive Motion	
	Banged into object		Hit by Falling object				Foreign object in eye		Noise Exposure
	Burn		Allergy/Unknown Reaction			Infectious disease		Workplace Violence	
Accident with motorized Cut/Scratch/Abrasion by object vehicle									
If not listed, please describe in comments below:									
Comments:									

Medical Action (Please check all that apply)						
No medical action	First aid only	Medical treatment beyond first aid.	Note: Workers' Compensation is notified by the completion and submission of this on-line form			
Went/plans to go to (check all that apply): Medi Center Specialis						
Own Doctor Hospital						
If admitted to Hospital please put complete name, address, and phone number of facility						
I.						

Supplemental Information						
Date Supervisor was informed of incident:						
Employee's E-mail	Do you have a second job?					
address:	(Yes) (No) :					
Date of this report:	Where:					
Printed name of person completing this report:						

Prior to sending the completed form, please print a copy for your records using your browser's print function. Also be sure that the employee gets a copy of the completed incident report form.

Please save this form and attach it to an e-mail. Send to reilly@hope.edu

QUESTIONS? Contact the Occupational Safety Office at **(616) 395-7999** or e-mail (reilly@hope.edu.)

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