



Report of Injury/Incident/Hazard

Center for Environmental Health and Safety
 Southern Illinois University Carbondale
 1325 Radio Drive
 Mail Code 6898
 http://www.cehs.siu.edu
 Ph. (618)453-7180 Fax (618)453-7192

Case Number _____

It is the responsibility of each supervisor to ensure that this report is filed with the Center for Environmental Health and Safety within 24 hours of becoming aware of an incident or hazard related to SIU facilities or operations.

I. PERSON INVOLVED IN INCIDENT	Name (Last, First, Mi)		Sex <input type="checkbox"/> F <input type="checkbox"/> M	E-Mail
	Date Of Birth			AIS or Dawg Tag # (if appropriate)
	Address (Local)			Phone (W) _____ (H) _____
	Status At Time Of Incident <input type="checkbox"/> Employee <input type="checkbox"/> Visitor <input type="checkbox"/> Student <input type="checkbox"/> Other (Specify):		If An Employee , Give Job Title And Department	If A Visitor , State Purpose Of Campus Visit
	IF OTHERS WERE INVOLVED, ATTACH ADDITIONAL COPIES OF THIS FORM FOR EACH PERSON.			
Did Incident Arise Out Of And In The Course Of University Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No				
II. INCIDENT/ OR HAZARD DESCRIPTION	Place Where Accident/Incident Occurred Or Hazard Is Located		Date & Time Of Incident	Name Of Area Supervisor Where Incident Occurred Or Hazard Is Located.
	Describe Activity Being Performed By Person Involved In Incident (I.E. Driving Truck, Lifting Crate, Etc.)			
	Fully Describe Incident/Hazard (Attach Additional Sheets If Necessary.)			
	List Any Witness Present Name	Address		Phone (W) _____
	Additional Witness(es) Present Name	Address		Phone (W) _____
III. INJURY	Did This Incident Result In Injury To The Person Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	IF INJURY OR ILLNESS RESULTS FROM AN INCIDENT ARISING OUT OF AND IN THE COURSE OF UNIVERSITY EMPLOYMENT, THE INJURED PERSON OR THEIR SUPERVISOR (If injured person is unable) MUST CALL TRISTAR Risk Enterprise Management, Inc. AT 1-855-495-1554 AND REPORT THE INJURY OR ILLNESS.			
	Describe Nature And Scope Of Personal Injury, If Any			
Was Medical Care Sought? <input type="checkbox"/> No <input type="checkbox"/> Yes: Place & Date of Treatment _____				
IV. PROPERTY DAMAGE	Describe Property Damage, If Any			
V. SIGNATURE	Printed Name Of Person Completing Form			Job Title/Occupation
	Signature Of Person Completing Form _____ Date _____			Phone Number (W) _____ (H) _____