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:

Employee Work Status:

(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:
- 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?
- Did employee receive training on how to prevent this type of injury?

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)

☐ 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:

_____ Name of exposed 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 vehicle	☐	Cut/Scratch/Abrasion by object				

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 ☐ Specialist ☐ Own Doctor ☐ Hospital			
If admitted to Hospital please put complete name, address, and phone number of facility			

Supplemental Information	
Date Supervisor was informed of incident:	
Employee's E-mail address:	Do you have a second job? (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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