Southwestern Oregon Community College Injury/Accident Report

PLEASE COMPLETE THIS REPORT IF YOU ARE INVOLVED IN AN INCIDENT, SUSTAIN AN INJURY, OR ARE WITNESS TO AN INCIDENT OR INJURY

STUDENT INJURIES: Separate form must be completed by the INJURED STUDENT and ALL WITNESSES. Note, students are not covered by College accident insurance.

EMPLOYEE INJURIES: Separate forms must be completed by the INJURED WORKER and ALL WITNESSES. ALL WORK RELATED INJURIES MUST BE REPORTED TO ADMINISTRATIVE SERVICES **IMMEDIATELY**.

NOTICE TO STUDENTS: You must give your current, local address and phone number—where you can be reached now—do not give your parent's address unless you live with them **now**.

Your Name:_____

Street Address:_____

City, State, Zip:_____

Campus Phone:_____ Home Phone:_____

Your Job Title: _____

Name of Person Involved:_____

Employee_____ Student Worker_____ Student_____ Visitor_____

Volunteer_____ Practicum Student_____ Other_____

Relationship to Person Involved: ☐self ☐witness ☐instructor ☐other_____

Gender of Person Involved: ☐ Male ☐ Female

Date of Incident: _____ Time of Incident: _____ ☐ AM ☐ PM

Incident Location: _____

Incident occurred during: ☐Class (specify which class) ☐Employment ☐Other_____

Injury occurred to: ☐self ☐other ☐N/A

WITNESSES – List all witnesses to the incident/injury

Name: _____ Phone: _____ Staff: ☐YES ☐NO

Street Address:_____

City, State, Zip:_____

Name: _____ Phone: _____ Staff: ☐YES ☐NO

Street Address:_____

City, State, Zip:_____

Describe what happened, how it happened, and why it happened: Be specific and detailed enough so that anyone reading this report will understand the nature and extent of the incident. Include events that occurred immediately before the incident/accident.

Please check one: ☐Injury ☐Non-Injury Accident ☐Criminal Activity ☐Other

_____

_____

_____

_____

_____

Authority Reported to: ☐Campus Security ☐College Maintenance Dept. ☐College Official (VP, President, etc.)
☐Coos Bay Police ☐North Bend Police ☐Coos County Sheriff's office
☐Oregon State Police ☐Other Agency_____

Was Campus Security Notified? ☐YES ☐NO

Was Administrative Services Notified within 24 hours? ☐Yes ☐No Date Administrative Services notified: _____

Was the accident caused by faulty equipment? ☐Yes ☐No If yes, preserve evidence and identify.

Name of Your Supervisor:_____ Phone:_____

Your Signature:_____ Date:_____

Injury

Was the injury caused by another person? ☐Yes ☐No If yes, who?

Name:_____ Phone:_____

Has this body part been injured before? ☐Yes ☐No If yes, please explain:_____

_____

_____

First Aid Given? ☐YES ☐NO If yes, please indicate the type of first aid:

☐ Ice ☐ Washed Wound ☐ Kept Immobile ☐ Stopped Bleeding

☐ Observed ☐ Applied Splint ☐ Applied Dressing ☐ Other _____

Who administered first aid?_____Phone:_____

Did you/the injured person receive medical treatment beyond first aid? ☐YES ☐ NO

Treatment required: ☐None ☐Visit to doctor ☐Ambulance ☐Hospitalization ☐Emergency Room ☐Overnight Hospitalization

Note: If you checked "none" and later feel you need to see a doctor for this injury, call Administrative Services at x7206.

Body Part Injured*: **Using L for Left and R for Right, indicate your injuries below**

HEAD	TRUNK	EXTREMITIES		OTHER
__ Ear	__ Abdomen	__ Ankle	__ Lower Arm	_____
__ Eye	__ Back	__ Elbow	__ Lower Leg	_____
__ Face	__ Chest	__ Finger	__ Thumb	_____
__ Head	__ Groin	__ Foot	__ Toes	_____
__ Neck	__ Shoulder	__ Hand	__ Upper Arm	_____
__ Scalp	__ Trunk	__ Knee	__ Wrist	_____

Type of Injury Suspected:

☐ Laceration/Abrasion ☐ Bruise/Contusion ☐ Sprain/Strain ☐ Fall

☐ Dislocation ☐ Fracture ☐ Concussion

☐ Surface Cut/Scratch ☐ Burn ☐ Other_____

I certify, as attested by my signature below, that all information I have given is true and contains no false statements and/or misrepresentations.

Print Your Name:_____

Your Signature: _____ Date: _____

Supervisor

Date Reported: _____ Time: _____ ☐am ☐pm To Whom? _____

Were other workers injured? ☐Yes ☐No If yes, please name: _____

Additional Comments: _____

I certify, as attested by my signature below, that all information I have given is true based on my knowledge of the incident.

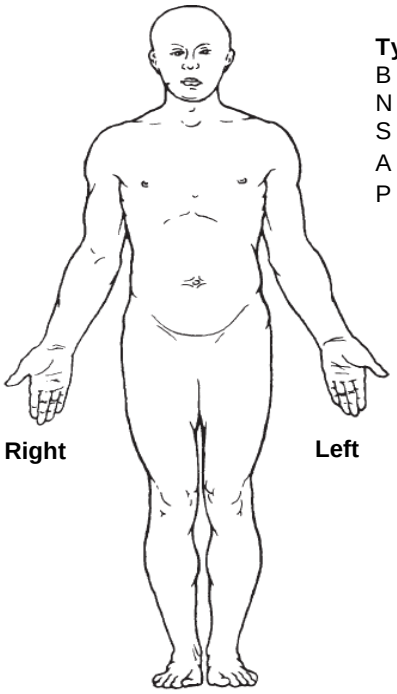
Supervisor Printed Name: _____

Supervisor Signature: _____ Date: _____

Pain Diagram

This Pain Diagram needs to completed and submitted to Administrative Services. Please retain a copy for your own records.
Please mark the area of injury or discomfort on the chart below using the appropriate symbols:

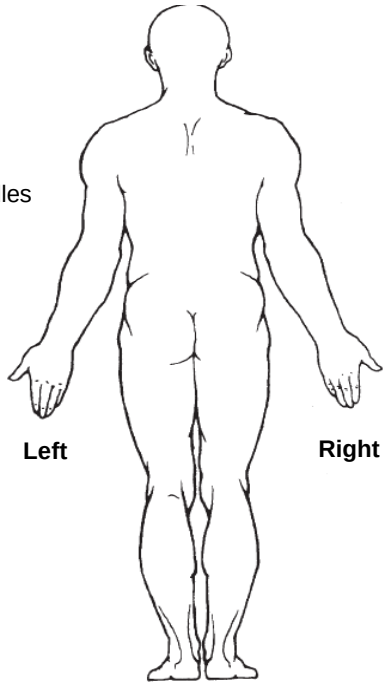
Front



Right **Left**

Type of Pain
B = Burning
N = Numbness
S = Stabbing
A = Aching
P = Pins & Needles

Back



Left **Right**

Pain Scale

0 *= No Pain*

10 _____ *= Severe Pain*

Check one: ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7 ❍ 8 ❍ 9 ❍ 1 0

Please use the space below to describe your condition further, if needed:

_____

_____

I certify, as attested by my signature below, that all information I have given is true and contains no false statements and/or misrepresentations.

Your Printed Name: _____

Your Signature: _____ Date: _____

What corrective action was taken, or is planned, to prevent similar accidents from occurring I the future: _____

_____

_____

_____

_____

RETURN COMPLETED FORM TO ADMINISTRATIVE SERVICES IN TIOGA HALL