



# 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**

<u>HEAD</u>	<u>TRUNK</u>	<u>EXTREMITIES</u>	<u>OTHER</u>
__ 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: \_\_\_\_\_

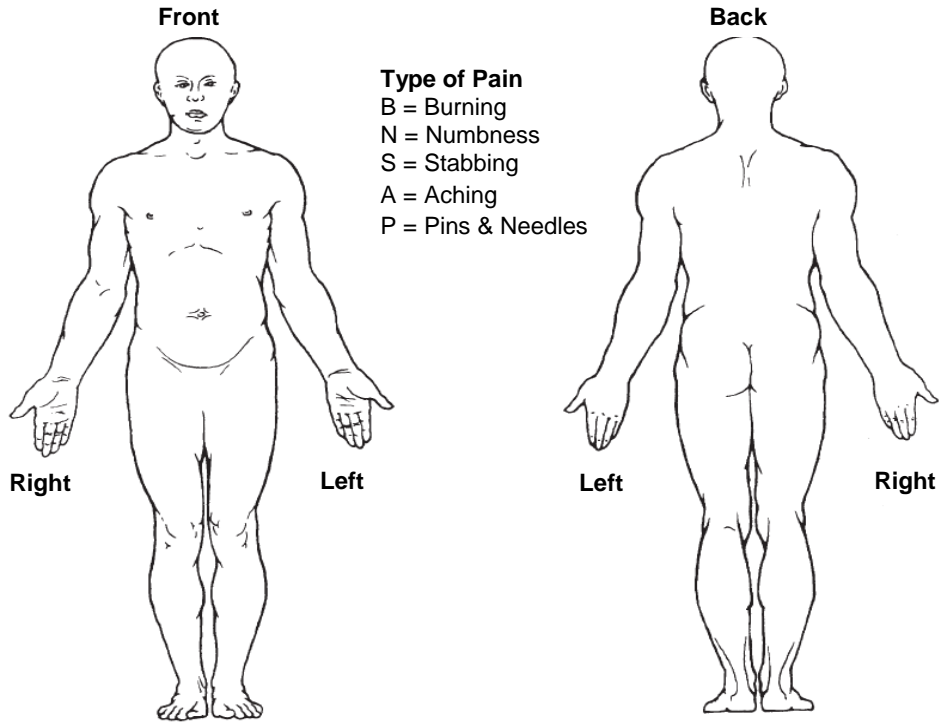
I certify, as attested by my signature below, that all information I have given is true based on my knowledge of the incident.

Supervisor Printed Name: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Pain Diagram

This Pain Diagram needs to be 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:



### Pain Scale

0 = No Pain \_\_\_\_\_ = Severe  
10

Pain

Check one:  0  1  2  3  4  5  6  7  8  9  10

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

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*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 in the future: \_\_\_\_\_

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**RETURN COMPLETED FORM TO ADMINISTRATIVE SERVICES IN TIOGA HALL**