

Must submit completed form to the Office of Safety within 24-hours of incident.

Please fill in ALL fields.

If a field doesn't apply, please type in 'N/A'.

Type of Incident: Near Miss Slight Injury/Illness (not requiring professional medical attention)
 Injury/Illness (requiring professional medical attention – *give the Office of Safety the Doctor's Report of Injury as soon as possible*)
Person completing form: Last name: _____ First name: _____ Phone: _____
Date incident occurred: _____ **Time:** _____ **Date employer was notified:** _____
Who was notified? _____

PART A: COMPLETE THIS PART OF FORM FOR ALL INCIDENTS

Injured/Involved person: Last name: _____ First name: _____ EMPLID: _____
Local address (include city, state, zip code): _____
Phone: _____ **Email:** _____
Sex: Female Male **Marital Status:** _____ **Name of parent/guardian (if under 18):** _____
Injured/Involved person's relationship to UND: Employee/Student Employee Student (non-employee) Visitor
Employing Department: _____
Supervisor: _____ **Supervisor's email:** _____ **Phone:** _____
Job title of injured person: _____ Part-time Full-time
Address, building name, location of incident: _____
Was the incident: Inside Outside **If Outside:** Clear Raining Snowing Other _____
Description of incident: _____

Was injury/illness work related? Yes No If Sharps related complete [Sharps Injury Form](#) (see Sharps policy)

If an Adverse Event complete [Institutional Biosafety Adverse Event Reporting Form](#) (see IBC Policies/Procedures)

Injury and illness information: No apparent injury or illness Slight injury or illness
 Injury or illness requiring professional medical attention – COMPLETE PART B (not requiring professional medical attention)

Body part(s) injured: BE SPECIFIC, include left/right/bilateral: _____

Last date worked prior to date of incident: _____ **Time lost from work** (number of days and/or hours): _____
NOT the incident date

Witness(es) to incident: Name(s) _____ Phone: _____

PART B: COMPLETE THIS PART IF INJURY OR ILLNESS REQUIRED PROFESSIONAL MEDICAL ATTENTION

Medical facility: _____ **City:** _____ **State:** _____

Physician: _____ **Date of initial treatment:** _____

Description of medical treatment (s): _____

Be sure to contact the Office of Safety 701.777.3341 with your Social Security Number & Date of Birth as both are required to file a claim

The above information on this report is accurate based on my knowledge of the incident,

Click [here](#) to send this form to the Office of Safety. You can also save and email it to und.safety@email.und.edu and your Supervisor

Signature _____ **Date** _____

Supervisor's signature _____ **Date** _____

Office of Safety _____ **Date** _____

PRINT

Submit to Safety

SMHS Only

Housing Only

Wellness Center Only