Suffolk University Incident Report Form
Office of Environmental, Health, & Safety

Suffolk University officials require **all injuries** be reported that are sustained while on University property and/or while participating in University recognized activities. This report should be completed no matter how minor the injury may have been. A Suffolk University representative must complete all sections of this form **within 24 hours** after the injury is first reported. Once completed, a copy of this report must be sent to the Department Chairperson or Supervisor and the Office Environmental Health and Safety (OEHS) by Email to OEHS@Suffolk.edu or fax # (617)-725-7105. Please provide thorough answers to all applicable sections.

For automobile accidents, in addition to completing this form you must also contact the Risk Manager at (617) 973-1141. For further information or if you have any questions, please contact the OEHS at (617) 570-4849 or 573-8628.

**Suffolk University Incident Report**

*I hereby verify that the following information is correct and accurate to the best of my knowledge.*

**Part 1. Suffolk Incident Identifier Information (representative filling out this form):**

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Daytime Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Job Title</th>
<th>Employee Department</th>
<th>Employee Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>City, State</th>
<th>Postal Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did anyone witness the incident?</th>
<th>Witness Name(s)</th>
<th>Witness Telephone Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Part 2. Injured Person Information:**

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Job Title (if applicable)</th>
<th>Employee Department</th>
<th>Employee Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>University Employee Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Male ☐</td>
<td>☐ Full Time Employee ☐ Student</td>
</tr>
<tr>
<td>☐ Female ☐</td>
<td>☐ Part Time Employee ☐ Non-Employee</td>
</tr>
</tbody>
</table>
### Part 3. The Injury / Illness:

<table>
<thead>
<tr>
<th>Date of Incident</th>
<th>Time of Incident</th>
<th>Address of Incident (Bldg# &amp; rm#)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>[ ] a.m.  [ ] p.m.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incident Reported By (name)</th>
<th>Incident Reported To (name)</th>
<th>Supervisor In Charge (if applicable)</th>
</tr>
</thead>
</table>

Where did the incident occur? Please be as specific as possible, building & room number or in relation to a known fixed object. Example: In the stairwell #2 of the Donahue building going down to the cafeteria.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Is this location a laboratory?    Yes   No

What was the individual doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the individual was using. Be specific. Examples: climbing a ladder while carrying a paint can; spraying chorine from a hand sprayer; daily computer key-entry.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

What happened? Explain how the injury occurred. Examples: When ladder slipped on wet floor, worker fell 20 ft; worker was sprayed with chorine when gasket broke during replacement; worker developed soreness in wrist over time.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

What is the injury or illness? Identify the part of the body that was affected and how it was affected. Indicate left or right. Please be more specific than "hurt", "pain", or "sore". Examples: "twisted left ankle", "chemical burn on lower left arm"; "one inch cut on right wrist".

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
Part 3B. Bloodborne Exposure Injury / Illness (if applicable):

<table>
<thead>
<tr>
<th>Employee Hepatitis B Vaccine Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received vaccine: ☐ Yes ☐ No</td>
</tr>
<tr>
<td>Completed all three segments of vaccine: ☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Exposure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Skin Puncture ☐ Splash to broken skin ☐ Splash to Eyes / Nose / Mouth</td>
</tr>
<tr>
<td>☐ Unvaccinated First Responder:</td>
</tr>
<tr>
<td>☐ Contact with bleeding person using gloves or PPE</td>
</tr>
<tr>
<td>☐ Contact with bleeding person without gloves or PPE</td>
</tr>
<tr>
<td>☐ Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source of Blood or Body Fluid Causing Exposure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Path Waste ☐ Sharp Equipment / Tool ☐ First Aid Assistance</td>
</tr>
<tr>
<td>☐ “Sharps” Type ______ Brand ______</td>
</tr>
<tr>
<td>☐ Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was a Sample of the infectious source saved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

If Yes, where is the sample?

Source Patient’s name if known:

<table>
<thead>
<tr>
<th>Severity of Injury:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Minor First Aid ☐ Severe Non-Disabling ☐ Disabling</td>
</tr>
<tr>
<td>☐ Fatality ______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factors in Incident (Be Specific):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Unsafe Act</td>
</tr>
<tr>
<td>☐ Unsafe Condition ____________________</td>
</tr>
</tbody>
</table>

Corrective Action Taken:

Part 4. Response / Treatment:

Who responded to the incident scene? (Please check all that apply)

<table>
<thead>
<tr>
<th>Suffolk University Police and/or Security ☐ Environmental, Health, &amp; Safety Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Health Services ☐ Resident Assistant</td>
</tr>
<tr>
<td>☐ Other (Name) ____________________________ ☐ No One</td>
</tr>
</tbody>
</table>

What treatment was received? (Please check all that apply)

<table>
<thead>
<tr>
<th>☐ No Treatment ☐ First Aid ☐ Beyond First Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Treatment Refused ☐ Unknown</td>
</tr>
</tbody>
</table>

Please describe the treatment given. (State none if applicable.)

Was the individual treated in an Emergency Room?

<table>
<thead>
<tr>
<th>☐ Yes ☐ No</th>
</tr>
</thead>
</table>

If Yes, Name of Hospital treated at:

<table>
<thead>
<tr>
<th>☐ NEMC ☐ Mass General ☐ Health Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Other (Name) __________________________</td>
</tr>
</tbody>
</table>

Revision Date: 10/1/10
### Part 5. Signatures:

#### Injured Acknowledgement and Signature

I have been apprised that I may seek medical attention and would like to do so.

Signature: ___________________________ Date: ______________

or

I have been apprised that I may seek medical attention but **decline** to do so.

Signature: ___________________________ Date: ______________

#### Witness Signature

Signature of Witness: ___________________________ Date: ______________

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*Please send a copy to the
Department Chairperson or Supervisor
&
Office of Environmental, Health & Safety (OEHS)
Fax # (617)-725-7105
Email: OEHS@suffolk.edu*