



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

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) at **fax# (617) 305-1723**. Please provide a thorough answer 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):*

First Name	Last Name	Daytime Telephone Number
Employee Job Title	Employee Department	Employee Telephone Number
Home Address	City, State	Postal Code
Did anyone witness the incident?	Witness Name(s)	Witness Telephone Number(s)
<input type="checkbox"/> Yes <input type="checkbox"/> No		

Part 2. Injured Person Information:

First Name	Last Name	
Employee Job Title <i>(if applicable)</i>	Employee Department	Employee Telephone Number
Home Address	City, State	Postal Code
Sex	University Employee Status	
<input type="checkbox"/> Male	<input type="checkbox"/> Full Time Employee	<input type="checkbox"/> Student
<input type="checkbox"/> Female	<input type="checkbox"/> Part Time Employee	<input type="checkbox"/> Non-Employee

Part 3. The Injury / Illness:

Date of Incident	Time of Incident	Address of Incident (Bldg# & rm#)
	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Incident Reported By (name)	Incident Reported To (name)	Supervisor In Charge (if applicable)

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 chlorine 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 chlorine 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):

Employee Hepatitis B Vaccine Status:	
Received vaccine: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Completed all three segments of vaccine: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Exposure:	
<input type="checkbox"/> Skin Puncture <input type="checkbox"/> Splash to broken skin <input type="checkbox"/> Splash to Eyes / Nose / Mouth <input type="checkbox"/> Unvaccinated First Responder: ___ Contact with bleeding person using gloves or PPE ___ Contact with bleeding person without gloves or PPE <input type="checkbox"/> Other:	
Source of Blood or Body Fluid Causing Exposure:	
<input type="checkbox"/> Path Waste <input type="checkbox"/> Sharp Equipment / Tool <input type="checkbox"/> First Aid Assistance <input type="checkbox"/> "Sharps" Type _____ Brand _____ <input type="checkbox"/> Other:	
Was a Sample of the infectious source saved?	
<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, where is the sample? Source Patient's name if known:	<input type="checkbox"/> Full Time Employee <input type="checkbox"/> Student <input type="checkbox"/> Part Time Employee <input type="checkbox"/> Non-Employee
Severity of Injury:	
<input type="checkbox"/> Minor First Aid <input type="checkbox"/> Severe Non-Disabling <input type="checkbox"/> Disabling <input type="checkbox"/> Fatality _____	
Factors in Incident (Be Specific):	
<input type="checkbox"/> Unsafe Act _____ <input type="checkbox"/> Unsafe Condition _____ Corrective Action Taken:	

Part 4. Response / Treatment:

Who responded to the incident scene? (Please check all that apply)
<input type="checkbox"/> Suffolk University Police and/or Security <input type="checkbox"/> Environmental, Health, & Safety Manager <input type="checkbox"/> Health Services <input type="checkbox"/> Resident Assistant <input type="checkbox"/> Other (Name) _____ <input type="checkbox"/> No One
What treatment was received? (Please check all that apply)
<input type="checkbox"/> No Treatment <input type="checkbox"/> First Aid <input type="checkbox"/> Beyond First Aid <input type="checkbox"/> Treatment Refused <input type="checkbox"/> Unknown Please describe the treatment given. (State none if applicable.) _____
Was the individual treated in an Emergency Room?
<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Hospital treated at: <input type="checkbox"/> NEMC <input type="checkbox"/> Mass General <input type="checkbox"/> Health Resources <input type="checkbox"/> Other (Name) _____

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: _____

****Please send a copy to the Office of Environmental, Health & Safety (OEHS) &
Department Chairperson or Supervisor****

OEHS fax# 617-305-1723