

## NON-EMPLOYEE INCIDENT/ACCIDENT REPORT FORM

## **The Catholic University of America**

SURNAME / FAMILY NAME:								
FIRST NAME:								
DAY AND DATE OF INCIDENT:								
		Day		Date				
TIME OF INCIDENT:	OF INCIDENT: TIME SHIFT COMMENCED:							
USUAL EMPLOYMENT LOCATION	l:							
LOCATION OF INCIDENT:  SITE NAME OR UNIQUE REFERENCE NUMBER								
EXACT LOCATION OF ACCIDENT: EXAMPLE-NEAR MAIN ENTRANCE, STOREROOM, IN CAR	R PARK, BEHIND WORKSH	OP, ETC.						
WHAT WAS THE INJURY OR INCII								
HOW DID THE INCIDENT HAPPEN OCCURRED? (DESCRIBE IN DETAIL WHAT CA	N? WHAT WERE USED THE INCIDENT. ATT	E YOU DOING WH	HEN THE INCID	DENT				
WHAT PROTECTIVE EQUIPMENT	WAS BEING US	SED OR WORN A	T THE TIME OF	THE ACCIDENT?				
DESCRIBE ANY MEDICAL TREATI	MENT OR FOLL	OW UP ACTION F	REQUIRED AFT	TER THE INCIDENT?				
WAS ANYONE ELSE INVOLVED IN	I THE INCIDENT			NETALL C				
WAS ANYONE ELSE INVOLVED IN	N THE INCIDEN	F YES, PLEA	SE PROVIDE L	JETAILS.				
CONSEQUENCE OF INCIDENT INJURY	PERSON AFFE	ECTED	PROPERTY I	DAMAGE				
☐ Fatality	☐ Customer		☐ Building:	\$				
Lost Time (Not available for normal work the day after an injury)	☐ Employee		☐ Tools:	\$				
☐ Medical Treatment	☐ Contractor		☐ Plant:	\$				
☐ First Aid			Other:	\$				
☐ No Injury								

Witness's names and contact number (attach witness statements if available)

Name		Contac	t Details			
To whom was the accident reported?						
When was the accident reported?						
In your opinion, what action if any, co	uld be taken	to prevent a	recurrenc	ce of the incider	nt?	
Was an ambulance called?		☐ Yes				
Were the police called?				ent No:		
Was Trauma Counseling Offered?	☐ No	☐ Yes	Date Contacted:			
Was Medical Treatment Sought?	☐ No	☐ Yes			<del></del>	
			Date &	Time:		
Employee Name		Signature			 Date	
Employee Name		0	igriature		Date	
SUPERVISORS USE ONLY						
To whom was the accident reported?						
Date and time accident reported?						
Supervisors Comments & Initial Inves	stigation Note	es:				
Target date for follow up action:						
Follow up action to be performed by	whom?					
Will the injured employee be off work	☐ No	☐ Yes				
Have all possible actions been taken	☐ No	☐ Yes				
Supervisor's Signature & Name					Date Signed	