

**CREIGHTON UNIVERSITY INCIDENT REPORT FORM HR-24
FOR ACCIDENT, INJURY OR BLOOD/BODY FLUID EXPOSURE REPORTING**

REPORT OF ALLEGED ACCIDENT. THIS REPORT MUST BE FILED WITH THE **RISK MANAGEMENT OFFICE**, WITHIN 24 HOURS AFTER THE ACCIDENT. DO NOT MAKE ANY STATEMENTS AND REFER ALL QUESTIONS TO THE RISK MANAGEMENT OFFICE.
TELEPHONE, (402)280-5833 OR FAX, (402)280-5719. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE SHEET.

PLEASE PRINT OR TYPE ALL INFORMATION

INJURED _____ EMPLOYEE _____ NON-EMPLOYEE (SPECIFY) _____

NAME: _____

HOME ADDRESS INCL. CITY, STATE AND ZIP CODE: _____

HOME PHONE #: _____ SOCIAL SECURITY #: _____

BIRTH DATE: _____ AGE: _____ SEX: M F MARITAL STATUS: _____

NAME AND ADDRESS OF RELATIVE OR FRIEND: _____

EMPLOYER IF OTHER THAN CREIGHTON: _____

ACCIDENT/INJURY

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____

LOCATION (BE SPECIFIC): _____

DESCRIBE IN FULL WHAT THE INJURED WAS DOING AND HOW THE ACCIDENT/INJURY/EXPOSURE HAPPENED:

DESCRIBE IN DETAIL NATURE AND EXTENT OF INJURY/EXPOSURE (SPECIFY THE LOCATION ON THE BODY. ALSO NOTE RIGHT OR LEFT):

CHECK TYPE OF INJURY:

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> LACERATION | <input type="checkbox"/> NEEDLE PUNCTURE WOUND | <input type="checkbox"/> SWELLING |
| <input type="checkbox"/> EYE SPLASH | <input type="checkbox"/> SORENESS/PAIN | <input type="checkbox"/> STRAIN/SPRAIN |
| <input type="checkbox"/> BRUISE | <input type="checkbox"/> FRACTURE | <input type="checkbox"/> OTHER (PLEASE EXPLAIN) |

FOR ANY ILLNESS FELT TO BE JOB RELATED: DESCRIBE THE ILLNESS TO INCLUDE THE CAUSE(S), TYPE OF ILLNESS, SYMPTOMS AND HOW THEY HAVE PROGRESSED INCLUDE DATE(S) AND CURRENT STATUS:

DID INJURED SEEK MEDICAL ATTENTION: YES NO
IF YES, NAME AND ADDRESS OF PHYSICIAN &/OR HOSPITAL: _____

PLEASE ATTACH COPY OF PHYSICIAN'S INSTRUCTIONS/RESTRICTIONS

NAME(S) OF WITNESS(ES) AND PHONE #: _____

EMPLOYEE INFORMATION ONLY

DEPT. PHONE # _____ TIME WORK DAY BEGAN _____ # OF HOURS WORKED WEEKLY _____

DID INJURED LOSE WORK DUE TO INJURY: _____ IF YES, DATE WORK LOSS BEGAN _____

DATE INJURED RETURNED TO WORK _____

SIGNATURE: _____ INJURED PARTY DATE _____

WAS A SUPERVISOR ON DUTY AT THE TIME OF ACCIDENT/INJURY/EXPOSURE YES NO IF YES, THEN SUPERVISOR MUST COMPLETE THIS SECTION

CONDITIONS OR CONTRIBUTING FACTORS TO ACCIDENT/ILLNESS/EXPOSURE: (PLEASE CHECK)

- | | | |
|---|--|--|
| <input type="checkbox"/> LIFTING TECHNIQUE | <input type="checkbox"/> DISTRACTION | <input type="checkbox"/> COMBATIVE PATIENT |
| <input type="checkbox"/> FAILURE TO WEAR PROTECTIVE EQUIP | <input type="checkbox"/> USE OF EQUIPMENT | <input type="checkbox"/> TOOLS OR EQUIP. |
| <input type="checkbox"/> FLOOR SURFACE/WALKWAY | <input type="checkbox"/> UNSAFE WORK AREA: | <input type="checkbox"/> OTHER: |
| <input type="checkbox"/> NONE | _____ | _____ |

CORRECTIVE ACTION TAKEN: _____

SIGNATURE: _____ SUPERVISOR DATE _____