

OSU Center for Health Sciences Injury Report

TO BE COMPLETED BY STUDENT/VISITOR						
Last Name	First	Mid Init.	CWID:	Sex: ___ M ___ F	Birthdate: (mm/dd/yy) ___/___/___	Work Phone#: _____ Home Phone#: _____
Dept/Unit Name:		Title:		Where did injury occur? Location: Rm # _____ Building _____		
Date of Injury (mm/dd/yy): ___/___/___ Time ___:___ AM/PM (Circle One)		Body Part Injured: Finger___ Hand___ (Right/Left) Arm___ (Right/Left) Head ___ Torso___ Leg___ (Right/Left) Other _____			Witness Name(s) and Phone #:	
Was injury reported on date it occurred? ___YES ___ NO If NO, please explain.						
To who was the injury reported?						
What was the date/time reported?						
Did you seek medical attention for this injury prior to reporting it? ___YES ___ No If YES, please explain.						
Describe how and what happened to cause this injury:						
Has body part been injured before? ___YES ___NO If YES, please explain.						
Student/Visitor Signature: _____			Date Completed: ___/___/___			
Type of Event	Contributing Condition	Contributing Behavior				
___ Struck by (what) _____ ___ Caught in/under/between ___ Overexertion ___ Patient Handling ___ Material Handling ___ Fall/Slip/Trip ___ Chemical or other exposure ___ Body fluid splash ___ Need lestick or Sharps ___ Other _____	___ Equipment defect or failure ___ PPE (personal protective equipment) unavailable ___ Work area set-up/arrangement ___ Floor/work surfaces ___ Ventilation ___ Lighting ___ Disassembling equipment ___ Safety device not activated (needle/sharp) ___ Lack of training ___ Other _____	___ Inattention to task ___ Rushing or hurried ___ Failure to get assistance ___ Not using assistive device (lift equipment) ___ Procedure not followed ___ Unbalanced/poor position or motion ___ Bypassing safety device ___ Failure to wear PPE ___ Lack of experience by other person(s) ___ Other _____				

		Other _____	
Action Taken to Prevent Reoccurrence (Check)			
<input type="checkbox"/> Scheduled safety training		<input type="checkbox"/> Ordered or posted hazard/warning signs	
<input type="checkbox"/> Developed/revised safety procedure		<input type="checkbox"/> Reported equipment/condition to _____	
<input type="checkbox"/> Ordered PPE		<input type="checkbox"/> Counseled Student _____	
<input type="checkbox"/> Took equipment out of service for repair/replacement		<input type="checkbox"/> Other _____	
<input type="checkbox"/> Reviewed policy/procedure			
Police/Safety Signature:		Phone #:	Date Completed: (mm/dd/yy) _/_/___