

**RICE UNIVERSITY**  
**ACCIDENT/INJURY REPORT**  
*Please Print*

**Section A: Details of incident**

- Injury                       Work related illness       Non work-related illness       Electrical incident
- Environmental incident       Property damage               Dangerous event               Laboratory incident

Name of person completing report: .....

Department: ..... Phone: .....

Date incident occurred: ..... Time incident occurred: ..... am / pm

Name of injured person: .....

Incident occurred while:

- At work               Traveling to/from work               On meal break               Other

Date reported: ..... Reported to: .....

Location of Incident: *(external area / building & room etc)*

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What happened? *(What were you doing at the time of the incident? Briefly describe how it happened.)*

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List any witnesses: *(names, telephone )*

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**Section B: Details of injured person and injury**

Student/Staff ID:..... M F Date of birth:.....

Telephone:..... Position title:..... Department:.....

Employment status:

- Faculty  Staff  Graduate student
- Undergraduate student  Visitor/member of public  Volunteer
- Other: .....

Employment basis:  Full-time  Part-time

Name of injured person's supervisor: .....

Details of treatment required:  None  Self  First aid \*\*  
 Hospital  Seen by other Medical Doctor

\*\*Describe first aid treatment given:

.....  
.....

Nature of injury:

- Allergy or sensitivity  Fracture/dislocation  Occupational overuse injury
- Respiratory  Burn / scalds  Exposure effects heat/cold
- Asphyxiation  Contusion/crush  Communicable disease
- Internal injuries  Puncture  Concussion or other neuro injury
- Fainting  Bruising  Skin condition eg dermatitis/ eczema
- Poisoning/toxic effects  Laceration/deep cut  Hearing loss
- Hernia  Sprain/strain  Vision impairment
- Foreign body  Nausea/vomiting  Electric shock or effects
- Amputation  Multiple injuries  Psychological disorder/stress effects
- Other .....

Part of body affected:

- Left  Back  Buttock  Forearm  Thigh  Head
- Right  Neck  Internal  Wrist  Knee  Face
- Groin /hip  Shoulder  Hand  Shin/calf  Ear
- Chest  Upper arm  Fingers/thumb  Ankle  Eye
- Stomach / trunk  Elbow  Foot/toe

Further description of injury/illness (if required):

.....  
.....

Agency of injury (what?)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Vehicle/transport       | <input type="checkbox"/> Radiation                       | <input type="checkbox"/> Thermal (heat/cold)           |
| <input type="checkbox"/> Lifting/ Carrying       | <input type="checkbox"/> Biological agent (eg pathogens) | <input type="checkbox"/> Animal/Insect                 |
| <input type="checkbox"/> Repetitive work         | <input type="checkbox"/> Chemical                        | <input type="checkbox"/> Mobile plant/equipment        |
| <input type="checkbox"/> Needle/sharp            | <input type="checkbox"/> Explosion/implosion             | <input type="checkbox"/> Machinery/fixed plant         |
| <input type="checkbox"/> Noise                   | <input type="checkbox"/> Non-power tool                  | <input type="checkbox"/> Workstation design            |
| <input type="checkbox"/> Electrical              | <input type="checkbox"/> Power tools                     | <input type="checkbox"/> Situation (violence, assault) |
| <input type="checkbox"/> Objects                 | <input type="checkbox"/> Surface (slippery/rough)        | <input type="checkbox"/> Psychological/social          |
| <input type="checkbox"/> Other (please specify): |  |  |
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Action/ mechanism which caused injury (*how?*)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Fall from height           | <input type="checkbox"/> Exposure to chemicals   | <input type="checkbox"/> Exposure to biological material |
| <input type="checkbox"/> Muscle stress – repetitive | <input type="checkbox"/> Exposure to electricity | <input type="checkbox"/> Hit by/trapped in moving object |
| <input type="checkbox"/> Muscle stress- loads       | <input type="checkbox"/> Exposure to heat/cold   | <input type="checkbox"/> Exposure to vibration           |
| <input type="checkbox"/> Hitting object             | <input type="checkbox"/> Exposure to radiation   | <input type="checkbox"/> Mental stress factors           |
| <input type="checkbox"/> Noise                      | <input type="checkbox"/> Insect/animal bite      | <input type="checkbox"/> Vehicle accident                |
| <input type="checkbox"/> Slip/trip                  | <input type="checkbox"/> Pressure                |  |
| <input type="checkbox"/> Other (please specify):    |  |  |
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Section C: Incident Investigation

*This section is to be completed by the local supervisor or department head for any incident involving personal injury, and for a serious incident or near miss where required.*

Identify any factors contributing to the incident.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Design issues                                     | <input type="checkbox"/> Environment (eg floor/ground surface)   | <input type="checkbox"/> Equipment malfunctioning         |
| <input type="checkbox"/> Inadequate supervision                            | <input type="checkbox"/> Inadequate space  | <input type="checkbox"/> Poor/lack of suitable equipment  |
| <input type="checkbox"/> Inadequate/ lack of training                      | <input type="checkbox"/> Unforeseeable event   | <input type="checkbox"/> Personal factors-stress, fatigue |
| <input type="checkbox"/> Failure to follow work procedures                 | <input type="checkbox"/> Inadequate safety procedures  | <input type="checkbox"/> Inadequate equipment maintenance |
| <input type="checkbox"/> Lack of experience                                | <input type="checkbox"/> Improper use/storage of materials   | <input type="checkbox"/> Poor housekeeping                |
| <input type="checkbox"/> Lack of appropriate Personal Protective Equipment | <input type="checkbox"/> Other environmental conditions (eg weather, lighting, ventilation, temperature) | <input type="checkbox"/> Other                            |
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Preventative/Corrective Actions:

*Describe the follow up actions planned or taken to prevent a similar incident.*

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Completion date \_\_\_\_\_

Supervisor/Department head signature \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> Copy filed with department                   | <input type="checkbox"/> Copy sent to Risk Management |
| <input type="checkbox"/> Copy sent to Environmental Health and Safety |   |