

# Mountain State University™

## Report of Accident/Incident/Safety Condition

### 1. INFORMATION REPORTED BY:

Name: \_\_\_\_\_  
 Faculty member     Staff member     Student     Visitor

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Event involved:     Accident     Incident     Safety Condition    Time: \_\_\_\_\_

### PERMANENT RESIDENCE INFORMATION:

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

### CAMPUS RESIDENCE/WORK INFORMATION (if applicable):

Building: \_\_\_\_\_ Room: \_\_\_\_\_ Campus Phone: \_\_\_\_\_ Campus email: \_\_\_\_\_

### 2. INJURIES (if applicable)

Person 1 Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Seek medical attention?     Yes (if YES go to line 2.a)     No (check one)

2.a Care Provider Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Person 2 Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Seek medical attention?     Yes (if YES go to line 2.b)     No (check one)

2.b Care Provider Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Person 3 Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Seek medical attention?     Yes (if YES go to line 2.c)     No

2.c Care Provider Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### 3. PROPERTY DAMAGE (if applicable)

Was there property damage?     Yes (if YES describe)     No

Damage Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 4. WITNESSES (if applicable)

Witness No. 1 Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Witness No. 2 Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### 5. EVENT DETAILS

Event Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Location: \_\_\_\_\_

Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 6. REPORTING (if applicable)

Did you report the event?     Yes (go to line 6a.)     No (go to line 6.b)

6a. Reported to: Name \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

6b. If you did not report this event explain why: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Note: This accident form is not intended to take the place of workers' compensation claim forms.)

I certify that all the above is true and correct to the best of my knowledge:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

\*If more than three persons were injured, continue by completing information on a separate piece of paper. Send this form and any attachments to: **Mountain State University-Department of Campus Safety P. O. Box 9003 Beckley, WV 25802-9003**

