

# Accidental Injury or Occupational Illness Report

**INSTRUCTIONS  
ON REVERSE**

**INJURED OR ILL PERSON**

NAME (Last, First, Middle Initial)	AGE	SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	CLASSIFICATION <input type="checkbox"/> Student <input type="checkbox"/> Employee <input type="checkbox"/> Visitor
ADDRESS	SCHOOL OR DEPARTMENT	TITLE OR STATUS	LENGTH OF EMPLOYMENT
CITY, STATE, ZIP	DATE and TIME of accident or initial diagnosis of occupational illness <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		HEALTH INSURANCE <input type="checkbox"/> Yes <input type="checkbox"/> No

**ACCIDENT OR EXPOSURE TO OCCUPATIONAL ILLNESS**

EXACT LOCATION OF ACCIDENT OR EXPOSURE	NAME OF SUPERVISOR/ BUILDING ADMINISTRATOR
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LOCATION OF OCCURRENCE  
 Cafeteria, Kitchen  Classroom  Grounds  Laboratory  Restroom  Shop  Stairs, Ramp  Other

DETAILS OF ACCIDENT OR EXPOSURE TO OCCUPATIONAL ILLNESS (What was the victim doing when injured? How did the accident or exposure occur? Name object or substance which injured victim. Use second sheet if necessary.)	ACTION TO PREVENT SIMILAR ACCIDENTS OR EXPOSURES (Indicate if taken or recommended)
	WITNESS (Name & Address)

**INJURY OR OCCUPATIONAL ILLNESS**

NATURE OF INJURY OR OCCUPATIONAL ILLNESS

<input type="checkbox"/> Amputation	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Respiratory conditions due to toxic agent	<input type="checkbox"/> Shock, Fainting
<input type="checkbox"/> Bruise, Contusion	<input type="checkbox"/> Exposure, Frostbite	<input type="checkbox"/> Internal injuries	<input type="checkbox"/> Sprains, Strains
<input type="checkbox"/> Burn, Scald	<input type="checkbox"/> Fracture	<input type="checkbox"/> Poisoning, Systemic effects of toxic material	<input type="checkbox"/> Suffocation, Drowning, Strangulation
<input type="checkbox"/> Concussion	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Disorders caused by non-toxic materials	<input type="checkbox"/> Rupture, Hernia
<input type="checkbox"/> Cuts, Open wounds	<input type="checkbox"/> Heat exhaustion, Sunstroke	<input type="checkbox"/> Disorders due to repeated trauma	<input type="checkbox"/> Other, Specify
<input type="checkbox"/> Skin disease disorders	<input type="checkbox"/> Dust diseases of lungs	<input type="checkbox"/> Shock, Electrical	

PART OF BODY INJURED OR AFFECTED (Indicate right or left)	BODY SYSTEM AFFECTED
<input type="checkbox"/> Head <input type="checkbox"/> Jaw <input type="checkbox"/> Back <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/> Ankle <input type="checkbox"/> Skull, Scalp <input type="checkbox"/> Neck <input type="checkbox"/> Pelvis <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Foot <input type="checkbox"/> Eye <input type="checkbox"/> Spine <input type="checkbox"/> Shoulder <input type="checkbox"/> Hand <input type="checkbox"/> Lower Leg <input type="checkbox"/> Toe <input type="checkbox"/> Nose <input type="checkbox"/> Chest <input type="checkbox"/> Upper arm <input type="checkbox"/> Finger <input type="checkbox"/> Other, Specify <input type="checkbox"/> Mouth <input type="checkbox"/> Abdomen <input type="checkbox"/> Elbow <input type="checkbox"/> Hip	<input type="checkbox"/> Circulation <input type="checkbox"/> Nervous <input type="checkbox"/> Digestive <input type="checkbox"/> Respiratory <input type="checkbox"/> Excretory <input type="checkbox"/> Reproductive <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Multiple Body

**TREATMENT**

ESTIMATE OF SEVERITY <input type="checkbox"/> Minor <input type="checkbox"/> Fatal, Specify date of death <input type="checkbox"/> Serious <input type="checkbox"/> Critical	EMERGENCY CARE <input type="checkbox"/> First Aid <input type="checkbox"/> Hospital, Specify <input type="checkbox"/> Private Physician <input type="checkbox"/> Health Center	NAME AND ADDRESS OF PHYSICIAN
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NUMBER OF DAYS TIME LOSS	DATES OF TIME LOSS
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THIS REPORT PREPARED BY: \_\_\_\_\_

TITLE OR STATUS: \_\_\_\_\_ DATE: \_\_\_\_\_

DEPARTMENT OR DIVISION: \_\_\_\_\_ SUPERVISOR SIGNATURE: \_\_\_\_\_

OCCUPATIONAL INJURY  OCCUPATIONAL ILLNESS

RISK MANAGER: \_\_\_\_\_

# CLOVER PARK TECHNICAL COLLEGE

## ACCIDENTAL INJURY OR OCCUPATIONAL ILLNESS REPORT

(PREPARE THIS REPORT FOR ANY INJURY WHICH MAY REQUIRE FIRST AID OR MEDICAL TREATMENT)

### STUDENT ACCIDENTS

1. All accidents, injuries or claims of occupational illness should be reported to your instructor immediately.
2. A report should be completed for each occurrence.

The report should be sent to your instructor, who will forward it to his/her supervisor, and forward to the Risk Manager.

3. If the accident or injury requires medical attention or emergency assistance, the Risk Manager should be notified immediately at 5537.

**NOTE:** Clover Park Technical College is not responsible for medical coverage for any student. Each student is encouraged to purchase school medical insurance or carry his/her own medical insurance.

### EMPLOYEE ACCIDENTS

1. All accidents, injuries or claims of occupational illness should be reported to your supervisor immediately.
2. A report should be completed for each occurrence.

Upon completion, this report should be sent to your immediate supervisor who will forward it to the Risk Manager.

3. If the accident or injury requires medical attention or emergency assistance, the Risk Manager should be notified immediately at 5537.
4. If an employee requires medical attention, he/she should request a Washington State Labor and Industries Industrial Accident form from the attending physician:
  - a. The employee will complete the necessary information on the employee's section of the form and leave the form with the physician.
  - b. The physician will complete his/her section of the form and forward to Clover Park Technical College Risk Manager, 4500 Steilacoom Blvd. S.W., Lakewood, WA 98499.
  - c. The Risk Manager will complete the employer's portion of the form and forward to the State Industrial Insurance Office for processing.

*THIS REPORT SHOULD BE PRINTED OR TYPED*