

MINNESOTA STATE UNIVERSITY, MANKATO
INCIDENT REPORT

Please fill out COMPLETELY and as DETAILED as possible

Today's Date: _____ SSN: _____

Name: _____ Work Phone: _____

Birthdate: _____ Marital Status: _____ Gender: Male Female

Date of Injury / Accident: _____

Time of Injury / Accident: _____ SPECIFIC
Location: _____

Employment Status: Part Time Full Time Student Temp. Other

Job Title: _____

Department Name: _____ Date Hired: _____ Hours Per Day: _____

Did the injured person miss work? Yes No Hourly Wage: _____ Days Per Week: _____

If so, how much time & date returned to work: _____

If Auto Accident:

Description of Vehicle Driver Lic #/State Owner/Dept. of Vehicle

Vehicle 1: _____

Vehicle 2: _____

State EXACTLY how the injury / accident occurred. (Attach additional sheets if necessary)

(If applicable, please indicate part of body injured / involved and complete the back of this form.)

Signature of Injured Person _____ Date

In the empty boxes, write the appropriate "Type of Injury" letter next to the number relating to the body part injured and the side of the body that is related to the injury. For example, if you bruised your left hip, you would put a "B" in box 16 under the L column. This will give an overall and precise picture of the nature of the injury.

AREA OF INJURY

- | | | | | | |
|---------------|----|--------------------------|--------------------------|---------------|----|
| Head..... | 1 | <input type="checkbox"/> | <input type="checkbox"/> | Hip..... | 16 |
| Face..... | 2 | <input type="checkbox"/> | <input type="checkbox"/> | Groin..... | 17 |
| Eye..... | 3 | <input type="checkbox"/> | <input type="checkbox"/> | Leg..... | 18 |
| Teeth..... | 4 | <input type="checkbox"/> | <input type="checkbox"/> | Thigh..... | 19 |
| Neck..... | 5 | <input type="checkbox"/> | <input type="checkbox"/> | Knee..... | 20 |
| Collarbone... | 6 | <input type="checkbox"/> | <input type="checkbox"/> | Shin..... | 21 |
| Shoulder..... | 7 | <input type="checkbox"/> | <input type="checkbox"/> | Ankle..... | 22 |
| Arm..... | 8 | <input type="checkbox"/> | <input type="checkbox"/> | Fingers..... | 23 |
| Elbow..... | 9 | <input type="checkbox"/> | <input type="checkbox"/> | Thumb..... | 24 |
| Forearm..... | 10 | <input type="checkbox"/> | <input type="checkbox"/> | Hand..... | 25 |
| Wrist..... | 11 | <input type="checkbox"/> | <input type="checkbox"/> | Big toe..... | 26 |
| Chest..... | 12 | <input type="checkbox"/> | <input type="checkbox"/> | Other toes... | 27 |
| Ribs..... | 13 | <input type="checkbox"/> | <input type="checkbox"/> | Instep..... | 28 |
| Back..... | 14 | <input type="checkbox"/> | <input type="checkbox"/> | Foot..... | 29 |
| Abdomen..... | 15 | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | <input type="checkbox"/> | <input type="checkbox"/> | | |

TYPE OF INJURY

- WOUNDS Laceration/Cut... A
 Bruise/Fracture... B
 Infection..... C
 Foreign Body..... D
 Puncture..... E

- EYES Foreign Body..... F
 Burn..... G
 Wound..... H
 Irritation..... I

- BURNS Heat..... J
 Chemical..... K
 Friction..... L

- SKIN Irritation/Rash... M

- NOXIOUS GASES Nausea..... N
 Dizziness... O
 Irritation.. P

- FRACTURE..... Q
 STRAIN..... R
 SPRAIN..... S
 PAINS..... T
 MISCELLANEOUS..... U

