

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

