APPALACHIAN STATE UNIVERSITY
ACCIDENT REPORT

(This accident form is to be used to report any non-work related incident or when an employee does not get medical treatment for a job related injury.)

Department ________________________________

Injured Person:
Name ___________________________ Date of Birth ____/____/____ Sex _____
SSN __________________________ Staff _____ Student _____ Faculty _____ Other _____
Home Address ___________________________ Home Phone ___________________
_____________________________ Work Phone _____________________

Accident:
Location ___________________________ Date ____/____/____ Time _______
Class ___________________________ Instructor _______________________

Cause of Accident:
Describe how accident happened: __________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Nature of Injury: ________________________________________________________________

Did individual receive medical treatment? _______ Yes _______ No
If so, by whom: ________________________________________________________________

Kind of body fluid spilled: Blood _______ Vomits _______ Other _______

Amount of fluid spilled: ______________________

Who responded to clean up spill? ________________________________________________

_________________________________________ ________________________________
Signed by Person Submitting Report Date

Keep a copy of this report for Department Files and send the original to the Safety Office. Contact the Safety Office at ext. 4008 with questions regarding the use of this form.