**Creighton University Incident Report Form (HR-24) Risk Management Office**

For Accident, Injury or Blood/Body Fluid Exposure Reporting **402.280.5833; 402.280.5780 (fax)**

Report of Alleged Accident. This report must be filed with the *Risk Management Office* within 24 hours after the accident. Do not make any statements and refer all questions to the **Risk Management Office**.

**Please print or type all information.**  If additional space is needed, attach a separate sheet.

***Injured:*** [ ]  Employee [ ]  Non-Employee (specify)

Name: SS#:

Birth date: Age: Gender: [ ] M [ ] F Marital Status:

Home Address, City, State, & Zip:

Home Phone #: ( ) Employer (*if other than Creighton)*:

Name & Address of Relative/Friend:

***Accident/Injury Information:*** *Date* of Accident: *Time* of Accident:

*Location* (be specific):

**Describe in detail what the injured was doing and how the *accident* happened:**

**Describe in detail nature and extent of *injury/exposure*  (Specify location on the body -- also note right or left; If related to sharp device, include: Type & brand of device; Type & amount of fluid or material, & severity of exposure ):**

**Check type of *injury*:** [ ]  Laceration [ ]  Soreness/Pain [ ]  Needle Puncture Wound [ ]  Strain/ Sprain [ ]  Fracture [ ]  Eye Splash

[ ]  Swelling [ ]  Bruise [ ]  Other (explain):

**For any *illness* felt to be job-related: Describe the illness to include the cause(s), type of illness, symptoms, & how they have progressed including date(s) and current status:**

**Name(s) of Witness(es) & Phone #:**

**Did injured seek medical attention:** [ ]  No [ ]  Yes --- Attach a copy of Physician’s Instructions/Restrictions **and** provide Name & Address of doctor and/or hospital:

***Employee Information Only:*** Dept. Phone #: Time Work Day Began: # of hours worked weekly:

Did injured lose work due to injury: [ ]  No [ ]  Yes *If yes,* Date work loss began: Date returned to work::

**Injured Party Signature:** **Date**:

*Was a supervisor on duty at the time of accident/injury/exposure?* *[ ]  No* *[ ]  Yes -- If yes, supervisor must complete the following:*

**Conditions or Contributing Factors to Accident/Injury/Exposure:** (please check)

[ ]  Lifting technique [ ]  Distraction [ ]  Combative Patient [ ]  Use of equipment [ ]  Floor surface/ walkway

[ ]  Tools or Equipment [ ]  Failure to wear protective equipment [ ]  Unsafe work area

[ ]  None [ ]  Other (please explain):

**Corrective action taken:**

**Signature of Supervisor:** Date