

Individual Report of Incident

Weber State University

3850 Dixon Parkway Dept 1016

Ogden, UT 84408-1016

Phone: 801-626-6184

Fax: 801-626-6925

Please complete and return to HR Dept 1016

Reports should be turned in within 24 hours of the incident.

Employee Information	1. Last Name, First Name, Middle			2. Email		
	3. Home Address			4. W#		
	5. City, State, Zip Code			6. Home/Cell Phone		
	7. Date of Birth		8. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		9. Work Phone	
	10. Employment Type <input type="checkbox"/> Hourly <input type="checkbox"/> Contract <input type="checkbox"/> Other: _____	11. Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer <input type="checkbox"/> Other: _____		12. Job Title		
	14. Wage Rate \$ _____ per	<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Annual <input type="checkbox"/> Other: _____		15. Hours per Week		
	16. Department		17. Supervisor		18. Supervisor's Phone	
	19. Date of Incident	20. Time of Incident	21. Time Shift Began		22. Date Incident Reported	
	23. How Did the Incident Occur? (Please describe in detail)					
	24. Parts of Body Injured and Type of Injury (Please be specific) <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral					
25. Has this part of the body ever been injured before? (If yes, please describe in the space below) <input type="checkbox"/> No <input type="checkbox"/> Yes → Date of Previous Injury: _____ Describe previous injury: _____						
26. Was safety equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was it used? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe: _____						
27. Location where incident occurred			28. Witnesses: Names & Phone Numbers			
29. Medical Treatment <input type="checkbox"/> No Treatment Received (Skip to question 34) Date Treatment Received: _____ <input type="checkbox"/> On-site treatment <input type="checkbox"/> Emergency Room <input type="checkbox"/> IHC WorkMed <input type="checkbox"/> Hospitalization <input type="checkbox"/> Other: _____ (answer questions 30-33)		30. Physician Name		31. Telephone		
		32. Clinic/Hospital Name				
		33. Address				
34. What can be done to prevent future incidents of this type?						
35. Employee's Signature			Date			
_____			_____			

Be Careful Out There

www.weber.edu/ehs

Revised: 9/3/2020