UND INCIDENT REPORTING FORM

Must submit completed form to the Office of Safety within 24-hours (one business day) of incident.

Please fill in ALL fields. If a field doesn't apply, please type in 'N/A'.

Type of Incident: ☐ Near Miss ☐ Slight Injury/Illness (not requiring professional medical attention)
☐ Injury/Illness (requiring professional medical attention – *give the Office of Safety the Doctor's Report of Injury as soon as possible*)

Person completing form: Last name: _____ **First name:** _____ **Phone:** _____

Date incident occurred: _____ **Time:** _____ **Date employer was notified:** _____

Who was notified? _____

PART A: COMPLETE THIS PART OF FORM FOR ALL INCIDENTS

Injured/Involved person: Last name: _____ **First name:** _____ **EMPLID:** _____

Local address (include city, state, zip code): _____

Phone: _____ **Email:** _____

Sex: ☐ Female ☐ Male **Marital Status:** _____ **Name of parent/guardian (if under 18):** _____

Injured/Involved person's relationship to UND: ☐ Employee/Student Employee ☐ Student (non-employee) ☐ Visitor

Employing Department: _____

Supervisor: _____ **Supervisor's email:** _____ **Phone:** _____

Job title of injured person: _____ ☐ Part-time ☐ Full-time

Address, building name, location of incident: _____

Was the incident: ☐ Inside ☐ Outside **If Outside:** ☐ Clear ☐ Raining ☐ Snowing ☐ Other _____

Brief description of incident: _____

_____

Was injury/illness work related? ☐ Yes ☐ No If Sharps related complete **Sharps Injury Form** (see Sharps policy)

Was this a biosafety related adverse event associated with activity involved with an active IBC protocol? ☐ Yes ☐ No
If so, complete **Institutional Biosafety Adverse Event Reporting Form** (see IBC Policies/Procedures) **IBC Protocol #:** _____

Injury and illness information: ☐ No apparent injury or illness ☐ Slight injury or illness (not requiring professional medical attention)
☐ Injury or illness requiring professional medical attention – COMPLETE PART B

Any Medical attention MUST be with a Designated Medical Provider (DMP) - contact UND Office of Safety with questions on your DMP

Body part(s) injured: BE SPECIFIC, include left/right/bilateral: _____

Last date worked PRIOR to date of incident: _____ **Time lost from work** (number of days and/or hours): _____
NOT the incident date

Witness(es) to incident: Name(s) _____ Phone: _____

PART B: COMPLETE THIS PART IF INJURY OR ILLNESS REQUIRED PROFESSIONAL MEDICAL ATTENTION

Medical facility: _____ City: _____ State: _____

Physician: _____ Date of initial treatment: _____

Description of medical treatment (s): _____

Be sure to contact the Office of Safety 701.777.3341 with your Social Security Number & Date of Birth as both are required to file a claim

The above information on this report is accurate based on my knowledge of the incident,

Signature _____ **Date** _____

THIS FORM MAY BE SUBMITTED WITHOUT SUPERVISOR SIGNATURE TO ENSURE FORM IS RECEIVED WITHIN REQUIRED ONE-BUSINESS DAY NOTIFICATION.
SUPERVISOR SIGNATURE CAN THEN BE OBTAINED AND THE FORM RESUBMITTED.

Save and email this form to und.safety@email.und.edu and your supervisor for review and signature.

Supervisor's signature _____ **Date** _____

Supervisor's printed name _____

Office of Safety _____ **Date** _____

NOTIFY OFFICE OF SAFETY IMMEDIATELY (WITHIN 24 HOURS) FOR ALL INCIDENTS RESULTING IN PERSONAL INJURY

3851 Campus Road Stop 9031 Grand Forks, ND 58202 Tel: 701.777.3341 Fax: 701.777.4132 Email: UND.safety@UND.edu