Central Michigan University

ACCIDENTAL PERSONAL INJURY REPORT

***Please attach/include any paperwork that you may have received from any care that was initiated after the injury.**

- ☐ Visitor
- ☐ Vendor
- ☐ Student (non-employee)
- ☐ Other

This form should be completed and sent to the Interim Program Director within 24 hours after the accident
Please email to flann1ka@cmich.edu

Name of Injured Person: Date of Birth:

Address: Phone:

Exact Location of Accident:	Date of Accident:	Time: AM PM	Date Reported:

Activity that Caused the Injury:

Nature of Injury or Illness:

☐ abrasion or contusion	☐ concussion	☐ heat exhaustion	☐ poisoning
☐ bite	☐ fainting	☐ inhalation	☐ puncture
☐ blood to blood contact	☐ foreign body in contact or imbedded	☐ laceration	☐ shock, electrical
☐ burn	☐ fracture	☐ nosebleed	☐ sprain-strain

☐ Other (explain)

Part of body injured (be specific, i.e., left upper arm, third finger right hand, etc.): _____
_____

Describe clearly how the incident/accident occurred (attach supplemental pages, material – photos, diagrams, measurements):
_____
_____
_____

Identify acts and/or conditions which appear as primary cause: _____
_____

WITNESSES (people who saw the incident/injury)

Name	Address	Phone	where was witness in relation to the incident/injury
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

Describe machine, tool, substance, or product, if any, involved in the injury and how involved: _____
_____

Treatment rendered, if any (name of Dr., Hospital, first aid given, etc.): _____
_____
_____

Name of person completing report (PLEASE PRINT) Signature of person completing form

Department & Campus Address: Dept. Phone No.: Date of Report: