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|  **INCIDENT/ACCIDENT REPORT**(Other than Motor Vehicle or Employee/Volunteer Injury)STD. 268 (CP REV. 12-16) | Injury/Illness, Damageon Campusor at aUniversity Activity | ***This report should be completed******and distributed within 48 hours of******the incident. Attach any photos, maps, additional pages or diagrams*.** |
| **CONFIDENTIAL--ATTORNEY/CLIENT PRIVILEGED DOCUMENT** |
| **This is a CONFIDENTIAL report to provide information for use by legal counsel in the event a claim is filed against the State or its employees. Under no circumstances should information be given to anyone except authorized state officials.****INJURY TO EMPLOYEE OR REGISTERED VOLUNTEER: CONTACT WORKERS’ COMP AT 756-5427** |
| **INCIDENT DATE :**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TIME: | **POLICE NOTIFIED?** YES  NO  | **LOCATION** (Describe specific location of the incident. If needed, attach maps and mark location. |  CAL POLY STUDENT   VISITOR |
| **INJURED PARTY INFORMATION** |
| **INJURED PARTY'S NAME** (Last, First, M.I.)  | **BIRTH DATE** | **TELEPHONE NUMBER** ( )  |
| **DESCRIBE HOW THE INJURY OCCURRED:** |
| **TYPE OF INJURY** (check box)**:**  Reaction to foreign substance/objects  Puncture  Laceration  Contusion  Burn  Fracture  Amputation  Sprain/Strain  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **PART OF BODY** (check box)**:**  Head Wrist Neck  Face Hand Shoulder  Eye Finger Groin  Ear Knee Other : Mouth Leg \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Ankle  Back Foot \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Trunk Toe  Arm Hip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **PHOTOGRAPHS TAKEN?**  YES NO IF YES, BY WHOM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **FIRST AID / MEDICAL TREATMENT GIVEN?** YES NO IF YES, BY WHOM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **WITNESS INFORMATION** |
| **NAME** (Last, First, M.I.) | **TELEPHONE NUMBER** |
| 1. | ( ) |
| 2. | ( ) |
| **DEPARTMENT REPORTING INCIDENT/ACCIDENT** |
| **CAMPUS OFFICE, DEPARTMENT, PROGRAM NAME:** |
| **EMPLOYEE'S NAME AND TITLE:** | **TELEPHONE NUMBER****( )** |
| **EMPLOYEE'S SIGNATURE** | **POSITION/TITLE** |
| **EMPLOYEE'S SUPERVISOR'S NAME AND TITLE:** | **TELEPHONE NUMBER****( )** |
| DISTRIBUTION: ORIGINAL—RISK MANAGEMENT OFFICE, BLDG 1 ROOM 128COPY—FAX COPY IMMEDIATELY TO (805)-756-6500 (Risk Management)COPY--RETAINED BY REPORTING DEPARTMENT, COLLEGE/DIVISION/PROGRAM OFFICE |



**INCIDENT/ACCIDENT REPORT**

STD. 268 (REV. 12-16)

**USE ADDITIONAL SHEETS AS NECESSARY**

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| **WAS THIS A CLASS, FIELD TRIP, FREETIME, LAB, LECTURE, OTHER?** Please describe in detail.  |
| **WERE THERE TOOLS, MATERIALS (CHEMICALS, COMPRESSED GAS, ETC), OR EQUIPMENT IN USE DURING THIS TIME?** Please describe in detail. |
| **WAS THERE SAFETY EQUIPMENT IN USE?**  YES NO  If “yes” please specify:  |
| **WAS SAFETY TRAINING PROVIDED PRIOR TO INCIDENT?**  YES NO  If “yes” please describe: |
| **DESCRIBE ANY CONDITIONS (INSIDE OR OUTSIDE) THAT MAY HAVE CONTRIBUTED TO THE INJURY:** |
| **WAS THERE A RELEASE AGREEMENT SIGNED BEFORE THE ACTIVITY?**  YES NO If “yes” please send the release with this report to Risk Management Office – Building 1, Room 128 |

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| **PROPERTY DAMAGE/LOSS INFORMATION** |
| **PROPERTY OWNER'S NAME** (Last, First, M.I.) | **TELEPHONE NUMBER****( )** |  **CAL POLY STUDENT**  **FACULTY/STAFF** **VISITOR** |
| **NATURE AND EXTENT OF DAMAGE / LOSS** (Describe in detail): |
|  |

**UNIVERSITY EMPLOYEES, (FACULTY, STAFF, STUDENT ASSISTANT, UNIVERSITY VOLUNTEER,) CORPORATION AND/OR ASI EMPLOYEES ARE TO REPORT INJURIES TO THEIR SUPERVISOR, REQUEST AND COMPLETE WORKERS COMPENSATION REPORT OF INJURY FORM FROM THEIR PERSPECTIVE EMPLOYERS, AND RETURN IT TO THE APPROPRIATE HUMAN RESOURCE DEPARTMENT.**