



CAL POLY

INCIDENT/ACCIDENT REPORT

(Other than Motor Vehicle or Employee/Volunteer Injury)

STD. 268 (CP REV. 2-22)

**Injury/Illness,
Damage on Campus
or at a
University 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 : _____	POLICE NOTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	LOCATION (Describe specific location of the incident. If needed, attach maps and mark location.)	<input type="checkbox"/> CAL POLY STUDENT <input type="checkbox"/> VISITOR
TIME: _____			

INJURED PARTY INFORMATION

INJURED PARTY'S NAME (Last, First, M.I.)	BIRTH DATE	TELEPHONE NUMBER
_____	_____	_____

DESCRIBE IN DETAIL HOW THE INJURY OCCURRED:

CAUSE OF INJURY (check box): <input type="checkbox"/> Animal <input type="checkbox"/> Bike Accident <input type="checkbox"/> Chemical <input type="checkbox"/> Fall <input type="checkbox"/> Fire <input type="checkbox"/> Flood <input type="checkbox"/> Person in act of crime <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Slip <input type="checkbox"/> Sports <input type="checkbox"/> Steam / Hot Fluids <input type="checkbox"/> Trip <input type="checkbox"/> Vehicle Accident <input type="checkbox"/> Other: _____	TYPE OF INJURY (check box): <input type="checkbox"/> Amputation <input type="checkbox"/> Burn <input type="checkbox"/> Contusion <input type="checkbox"/> Fracture <input type="checkbox"/> Laceration <input type="checkbox"/> Puncture <input type="checkbox"/> Reaction to foreign substance/objects <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Other: _____	PART OF BODY (check box): <input type="checkbox"/> Ankle <input type="checkbox"/> Arm <input type="checkbox"/> Back <input type="checkbox"/> Ear <input type="checkbox"/> Eye <input type="checkbox"/> Face <input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Groin <input type="checkbox"/> Hand <input type="checkbox"/> Head <input type="checkbox"/> Heart <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Leg <input type="checkbox"/> Mouth <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Toe <input type="checkbox"/> Trunk <input type="checkbox"/> Wrist <input type="checkbox"/> Other: _____
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PHOTOGRAPHS TAKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, BY WHOM _____	FIRST AID / MEDICAL TREATMENT GIVEN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, BY WHOM _____ HOSPITAL OR URGENT CARE: _____
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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
_____	_____



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USE ADDITIONAL SHEETS AS NECESSARY

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 or riskmanagement@calpoly.edu

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.