

Campus Security | Accident Injury Report

		This section for	official use only				
IR#:	Date Received:		Received by:				
Reporting Party	Please complete all fields		Affected Party				
Name:			Name:				
Date of Statement:			Street Address:				
Date / Time of Occurrence			City, State, Zip				
Location of Occurrence			Phone #:				
Reporter is:	Self Superviso	r Witness	Affected is:	Student	Staff		
	Other ()		Other ()	
Reporter SID / EID # (if applicable)			Affected SID / EID # (if applicable)				
Report Completed by:			Date of Birth:				
Reporter SID / EID # (if applicable)			Affected is:	Male	Female		
Date Hired: Job Title:							
Did the injury / illness occur while: working? in class? other?							
Date and time work or class began: Was Supervisor or Instructor notified? YES NO							
Supervisor / Instructor name: Title: Title:							
What were you doing before the incident?							
What Happened?							

Describe the injury / illness:
What object or substance directly harmed you?
If person died, when did death occur?
Was first aid administered? YES NO What treatment was given?
(full name / address / phone)
Witnesses (full name / address / phone) 1) 2) 2)
911 / Ambulance called? YES NO By Whom?
Injured person transported? YES NO Transported to where?
Transported by whom?
Name of treating physician or other health care professional:
If treatment was given away from worksite, where was it given? (facility name / full address):
Olympic College Employees – if you are injured at work and need treatment, go to the emergency room or the health care provider of your choice and tell them you were injured at work. They will assist you in filing the worker's compensation claim through Washington state Labor and Industries. If you have questions or concerns, please contact Human Resources @ (360) 475 – 7300.
Were you or will you be treated in an emergency room? YES NO
Were you or will you be hospitalized overnight as an in-patient? YES NO
What caused the accident / injury (in your opinion)?