LOYOLA UNIVERSITY NEW ORLEANS
Report of Accident / Incident Involving Employees or Others

☐ Employee ☐ Student ☐ Visitor ☐ Other

This form must be completed by any employee, student, visitor or other person for accidents or incidents involving his/her own injury or potential injury. A copy of this form MUST be submitted to Student Health Services (Campus Box 179).

GENERAL INFORMATION

Name Last First Middle Date of Birth:

Home Address: Home Phone:

Social Security No.: Department: Campus Phone:

Name of Supervisor: Campus Mailing Address:

DETAILS OF ACCIDENT / INCIDENT

Incident Date: Time: AM PM Location:

Description of What Happened:

Report What You Think Contributed to the Accident or Incident:

Type of Injury (Cut, Puncture, Burn, Etc):

State Body Part Injured (Left or Right):

Witness to Accident/Incident Name: Phone:

Signature of Injured/Report Party:

Signature of Supervisor: Date:

MEDICAL REPORT

To be completed at the treating facility/doctor

Diagnosis and Treatment:

Disposition: ☐Work ☐Hospital ☐Home _____ Days ☐ Refused Medical Care
Date: Time: AM or PM

Physician Referred to:

Name and Title of Person Completing Medical report: