

Complete form and send to EOHS within 24 hours
Cushwa Hall, Room 2046

**Youngstown State University
Accident/Incident Report**

Name _____ Employee Non-Employee Male/Female _____

Street Address: _____ Date of Birth _____

City, State, Zip _____ Home Phone # _____

Social Sec. # _____ Work Phone # _____

Date of Hire _____ Employee/Student ID # _____

Department _____ Supervisor/Instructor _____

Job Title _____ Supervisor/Instructor notified _____ am/pm

Incident Information

Date _____ Time _____ am/pm Location _____ Time began work _____ am/pm

What activity was being performed just before the incident? Describe what happened _____

Injuries/Illness? Yes No If yes, describe body parts affected. _____

Medical treatment? Yes No First Aid Emergency Room Student Health Services

If treated, Name of Health Care Provider. _____

Name/address/phone of facility. _____

Hospitalized overnight as an in-patient? Yes No

Witness? Yes No Name, address, phone. _____

I herein certify that the information set forth above is true and correct to the best on my knowledge.

Signature _____ Date _____