

**GENERIC INCIDENT REPORT FORM**

NAME \_\_\_\_\_ CWID# \_\_\_\_\_

DATE/TIME/ OF INCIDENT \_\_\_\_\_

LOCATION OF INCIDENT \_\_\_\_\_

**NOTE: STUDENT MUST GO TO STUDENT HEALTH SERVICES**

**DESCRIBE IN DETAIL THE INCIDENT. USE BACK IF NEEDED.** Include what you were doing just before the incident, what happened, what was the injury, if any.

**WHAT ACTION WAS TAKEN IMMEDIATELY AFTER THE INCIDENT?** Include treatment site, names of physicians or other health care providers, if possible.

**IF THE INCIDENT OCCURRED IN ANOTHER AGENCY, WAS AN INCIDENT REPORT MADE ON THEIR FORM?**

\_\_\_\_\_ YES. If yes, **please attach a copy to this form.**

\_\_\_\_\_ NO

**NAME, ADDRESS, AND PHONE NUMBER OF TWO PEOPLE WHO WITNESSED THIS**

**INCIDENT:**

1.

2.

STUDENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

FACULTY/SUPERVISOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Revised: 7/07, 10/13

Reviewed: 6/08, 7/09, 2/15, 6/17, 6/18, 8/19