

College Supervisor Incident Report
College of Food, Agricultural and Environmental Sciences

Name of Supervisor: _____ e-mail address: _____ Address: _____ _____ Phone: _____	Injured Position: (Check One) <input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate Student <input type="checkbox"/> Faculty <input type="checkbox"/> Staff <input type="checkbox"/> Post Doc <input type="checkbox"/> Visitor <input type="checkbox"/> Other: _____ _____
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Name of Injured: _____ Date of Incident: ____/____/____ Time of incident: _____ AM or PM	
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Location of Incident: _____
Type of Incident: <input type="checkbox"/> Fire <input type="checkbox"/> Chemical Spill <input type="checkbox"/> Medical Injury <input type="checkbox"/> Other: _____
Incident Occurred During: <input type="checkbox"/> Research <input type="checkbox"/> Lab Course (Course # & Experiment #) _____ <input type="checkbox"/> Other: _____
Was 911 or the University Police called? (If yes, circle which was called)
Was treatment needed? <input type="checkbox"/> Yes or <input type="checkbox"/> No
Did emergency personnel give the victim treatment? <input type="checkbox"/> Yes or <input type="checkbox"/> No
Did emergency personnel transport the victim? <input type="checkbox"/> Yes or <input type="checkbox"/> No
Did the victim refuse treatment or transport by emergency personnel? <input type="checkbox"/> Yes or <input type="checkbox"/> No
Was the victim wearing personal protective equipment (PPE) (gloves, goggles, safety glasses, lab coats, and etc.) <input type="checkbox"/> Yes or <input type="checkbox"/> No Please Specify: _____
Type of Injury (check all that apply): <input type="checkbox"/> Thermal Burn <input type="checkbox"/> Chemical Burn <input type="checkbox"/> Irritation of Eyes <input type="checkbox"/> Foreign object in Eye <input type="checkbox"/> Inhalation of Fumes/Dust <input type="checkbox"/> Slips/ Trips/ Strains/ Sprains <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Struck by Object/ Struck Against Object <input type="checkbox"/> Biohazard <input type="checkbox"/> Other: _____

Description of Incident (use the back of this form if necessary):
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Actions taken to prevent reoccurrence (use the back of this form if necessary):
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Supervisor Signature: _____ Date: ____/____/____
Name and Phone of Witness if available (use the back of form if necessary): _____
CC: <input type="checkbox"/> Tim Butcher <input type="checkbox"/> Safety Contact <input type="checkbox"/> Lori Weber <input type="checkbox"/> Dept HR Contact <input type="checkbox"/> Dept Chair