

ACCIDENT INVESTIGATION REPORT

This form is for minor injuries only. Call Campus Safety Dispatch at 836-5509 for all injuries resulting from falls, incidents involving emergency medical services, or an injury not listed below. Complete the following information **IMMEDIATELY** after the incident and email to the Office of University Safety at CampusSafety@MissouriState.edu. Keep a copy for your records.

Please Type or Print

Type of Accident:	Date of Accident:	Time of Accident:	Location of Accident:	
Injured Party Name: (First, Middle, Last)			Affiliation with University: <input type="checkbox"/> Faculty <input type="checkbox"/> Staff <input type="checkbox"/> Student <input type="checkbox"/> Vendor <input type="checkbox"/> Visitor	
Campus or Contact Address:		City:	State:	Zip:
BearPass Number: (M-Number)	Phone:	Email:		
Nature of Injury: <input type="checkbox"/> Bites/Stings <input type="checkbox"/> Bruise/Abrasion/Swelling <input type="checkbox"/> Minor Burn <input type="checkbox"/> Nosebleed <input type="checkbox"/> Winded <input type="checkbox"/> No Information <input type="checkbox"/> Other (Please identify) <input type="checkbox"/> _____		Body Area: <input type="checkbox"/> Arms/Shoulder/Elbow <input type="checkbox"/> Multiple Areas <input type="checkbox"/> Chest/Abdomen/Pelvis <input type="checkbox"/> Neck <input type="checkbox"/> Eyes <input type="checkbox"/> Spine/Back <input type="checkbox"/> Face <input type="checkbox"/> Teeth/Mouth <input type="checkbox"/> Feet/Toes <input type="checkbox"/> No Information <input type="checkbox"/> Fingers/Hands/Wrists <input type="checkbox"/> Other (Please Identify) <input type="checkbox"/> Head/Forehead <input type="checkbox"/> Legs/Knees/Ankles		
Was Emergency Treatment Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		Identify type of treatment provided:		Name of person performing the treatment:
Did the Individual Seek Further Medical Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were Photographs Taken of the Injury? <input type="checkbox"/> Yes – By: _____ <input type="checkbox"/> No		

Describe How the Accident Occurred:

Witness Information: Name / M-Number	Address:	Phone:	Email:

Name of Person Completing Report / M-Number Signature Date Completed

Name of Person Reviewing Report / M-Number Signature Date Reviewed