Missouri State | OFFICE of UNIVERSITY SAFETY

ACCIDENT INVESTIGATION REPORT

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: ☐ Faculty ☐ Staff ☐ Student ☐ Vendor ☐ Visitor

Campus or Contact Address:	City:	State:	Zip:

BearPass Number: (M-Number)	Phone:	Email:

Nature of Injury:

N01 ☐ Bruise/Abrasion/Swelling	N10 ☐ No Information
N02 ☐ Burn	N11 ☐ Nosebleed
N03 ☐ Concussion (Suspected)	N12 ☐ Open Wound/Laceration
N04 ☐ Crushed	N13 ☐ Sprain/Strain (Suspected)
N05 ☐ Dental Damage	N14 ☐ Winded
N06 ☐ Dislocation	N15 ☐ Bites/Stings
N07 ☐ Fatality/Death	N16 ☐ Other: (Please Identify) _____
N08 ☐ Fracture	
N09 ☐ Imbedded Object	

Body Area:

B01 ☐ Arms/Shoulder/Elbow	B09 ☐ Multiple Areas
B02 ☐ Chest/Abdomen/Pelvis	B10 ☐ Neck
B03 ☐ Eyes	B11 ☐ No Information
B04 ☐ Face	B12 ☐ Spine/Back
B05 ☐ Feet/Toes	B13 ☐ Teeth/Mouth
B06 ☐ Fingers/Hands/Wrists	B14 ☐ Other (Please Identify) _____
B07 ☐ Head/Forehead	
B08 ☐ Legs/Knees/Ankles	

Was Emergency Treatment Provided? ☐ Yes ☐ No	Identify type of treatment provided:	Name of person performing the treatment:

Was the Individual Advised to Seek Medical Treatment? ☐ Yes ☐ No	Were Photographs Taken of the Injury? ☐ Yes – By: _____ ☐ No

Was the Individual Hospitalized? ☐ Yes ☐ No	Name of Hospital:	Transported by: ☐ Ambulance ☐ Private Vehicle

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