

Non-Employee Incident/Injury Report

<p>THE PURPOSE OF THIS REPORT is to provide information which can be used in preventing similar accidents in the future.</p>	
<p>I. Individual Involved in Incident</p>	
<p>Name: <i>(Last, First, Middle Initial)</i></p>	
<p>Address: <i>(Street, City, State, Zip Code)</i></p>	<p>Phone Number 1: <i>(mobile)</i></p> <p>Phone Number 2: <i>(other)</i></p>
<p>Email: <i>(optional)</i></p>	
<p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	<p>Age:</p>
<p>Affiliation with Florida Polytechnic University:</p> <p><input type="checkbox"/> Student <input type="checkbox"/> Visitor <input type="checkbox"/> Employee (off duty) <input type="checkbox"/> Contractor/Vendor <input type="checkbox"/> Other Affiliation</p>	
<p>Student ID: <i>(if applicable)</i></p>	
<p>II. Incident Details</p>	
<p>Date of Incident:</p>	<p>Time of Incident:</p>
<p>Location of Incident: <input type="checkbox"/> On Campus <input type="checkbox"/> Off Campus</p>	
<p>Building and Room: <i>(if on campus)</i> or other location <i>(be specific)</i></p>	
<p>Program or Event: <i>(if applicable)</i></p>	
<p>Incident Description: <i>(Describe fully the events and conditions including how the incident occurred, why you were at that location and exactly what you were doing.)</i></p>	
<p>Injuries Sustained <i>(Describe in detail any and all injuries sustained)</i></p> <p><i>Note: Do not provide medical information or conditions other than the actual incident/injury sustained. If something arises due to an injured person's pre-existing medical condition, state it generically.</i></p> <p><i>Ex. "The injured person fainted due to a pre-existing medical condition."</i></p>	
<p>Law Enforcement Involvement: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Type: <i>(if law enforcement involved)</i></p> <p><input type="checkbox"/> FPU Police Department <input type="checkbox"/> Other: <i>(please specify)</i> _____</p> <p><input type="checkbox"/> Polk County Sheriff's Office <input type="checkbox"/> Report #: <i>(if applicable)</i> _____</p> <p><input type="checkbox"/> FHP</p>	
<p>Was treatment administered? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Medical Information: <i>(If treatment provided)</i></p> <p><input type="checkbox"/> First Aid only – not at hospital or by doctor</p> <p><input type="checkbox"/> Treatment at the University Health Center, Hospital or Medical Personnel</p> <p><input type="checkbox"/> Confinement at hospital or in residence</p> <p><input type="checkbox"/> Other (please specify) _____</p>	

III. Witness Information: (if applicable)

Witness Name 1: *(Last, First, Middle Initial)*

Witness Phone Number:

Witness Name 2: *(Last, First, Middle Initial)*

Witness Phone Number:

IV. Report Submitted by:

Name of FPU Employee or Representative: *(Last, First, Middle Initial)*

Are you the person in charge of the location or activity involved? Yes No

Department:

Phone Number:

Email:

Please email this completed document to John Trecastelli, Facilities and Safety Services,
safetyservices@floridapoly.edu. Thank you.