



## NON-EMPLOYEE INJURY/ILLNESS REPORT

This form is to be completed when a non-employee incurs an injury/illness at an A.S. event or within an A.S. facility. Please forward completed form to Contracts & Risk Management Coordinator.

### Section 1 – Non-Employee Information

Department \_\_\_\_\_

Name \_\_\_\_\_  Male  Female

Full Address \_\_\_\_\_ Phone \_\_\_\_\_

E-mail address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Student  Faculty/Staff  Minor  Other \_\_\_\_\_

Date of Injury \_\_\_\_\_ Time \_\_\_\_\_  AM  PM

Activity/Program \_\_\_\_\_

Location where event/exposure occurred \_\_\_\_\_

### Section 2 – Description of Injury/Illness *(Describe specific injury and part of body affected; include visual description of injury/illness. Only include a diagnosis if a medical professional has provided.)*

### Section 3 – How did the injury occur? *(Describe events, actions, conditions that resulted in injury Describe sequence of events. Specify object or exposure which directly produced the injury/illness. Provide only factual accounts and/or observations.)*

# NON-EMPLOYEE INJURY REPORT (Cont.)

## Section 4 – Action Taken

Emergency Services Called  Yes  No Time Called \_\_\_\_\_ Time Arrived \_\_\_\_\_

Transported Hospital/Medical Facility  Yes  No Where \_\_\_\_\_

First Aid/Medical Treatment  Yes  No Type \_\_\_\_\_

Administered by (name & title) \_\_\_\_\_

Medical Treatment Refused  Yes  No Offered by (name & title) \_\_\_\_\_

Care of Injured Transferred to: Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Section 5 – Witnesses** (if applicable – Please list witness contact information below. Should witnesses be able to provide a written statement, please attach on a separate page. No form or special format required.)

### Employee Witnesses

Name \_\_\_\_\_

Title \_\_\_\_\_

Name \_\_\_\_\_

Title \_\_\_\_\_

### Non-Employee Witnesses (if applicable)

Name (First & Last) \_\_\_\_\_

Phone Number \_\_\_\_\_

Name (First & Last) \_\_\_\_\_

Phone Number \_\_\_\_\_

**Section 6 – Special Remarks** (If applicable, provide additional information regarding the injury/illness that you believe is important.)

**Section 7 – Follow Up** (This section is to be completed by the Supervisor and/or Director/Assistant Director.)

Prepared by \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**Once completed, submit the form to your supervisor for review and processing.**

Supervisory review by \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Director/Assistant Director review \_\_\_\_\_ Date \_\_\_\_\_

*Please send completed form to Contracts & Risk Management Coordinator.*