The State University of New York System Administration

Visitor Accident Report

INJURED PERSON INFORMATION

Name: _____

Address: (Campus) _____

City/State/Zip: _____

Telephone: _____

Date of Birth: _____

Gender: ☐ Male ☐ Female ☐ Other

ACCIDENT INFORMATION

Date of Accident: _____ Time of Accident: _____

Reason in building/Event: _____

Location: (bldg/room) _____

List name(s) of witnesses: _____

Specific injury/illness and part(s) of body affected:

_____

How did accident occur? (Tell what happened and how it happened)

_____

_____

Describe any conditions that appeared to contribute to the accident or exposure to body fluids/chemicals (i.e., wet floor, horseplay, equipment)?

_____

Was another person involved in the accident or exposure to body fluids/chemicals? ☐ Yes ☐ No

If yes, explain _____

MEDICAL INFORMATION

☐ Accident Report Only-No First Aid required ☐ First Aid given

☐ First Aid and Ambulance Service ☐ Accident Report Only-First Aid required, but declined

Requires signature for declining treatment: _____ Date & time: _____

TREATMENT RECEIVED AT:

☐ **HOSPITAL** ☐ **PRIVATE PHYSICIAN** ☐ **OTHER**

Physician/Facility Name: _____ Address: _____

City/State/Zip: _____ Phone: _____

If hospitalized, please also complete if possible:

Hospital Name: _____ Address: _____

City/State/Zip: _____ Phone: _____

Completed by: _____ _____

(Print/Type name/title) **Signature** **Date**