ACCIDENT INFORMATION FORM





PLEASE COMPLETE ALL OF SECTION A AND ANY OF SECTIONS B-D THAT ARE RELEVANT TO THIS ACCIDENT/INCIDENT

SECTION A ACCIDENT/INCIDENT DETAILS				
REPORTED BY (WHO IS COMPLETING THE FORM):			OTHER PARTY/PARTIES INVOLVED IN ACCIDENT/INCIDENT:	
Name: Address: Street Address City State Zip Code			Name: Address: Street Address City State Zip Code	
Contact Information: Primary Secondary			Contact Information: Primary Secondary	
Supervisor:	Contact Info	rmation:		
Date and Time	Date and Time	LOCATION OF I	NCIDENT/ACCIDENT	
Accident/Incident Month Day Year A.M. P.M.	Reported	☐ Building:	Contact Info:	
INCIDENT TYPE: (Check All That Applies)		Brief Description of Accident/Incident:		
 □ Personal Injury/Illn □ Vehicle Accident □ Property Damage □ Work Related □ Other 	ness	_		
			DATE OF BIRTH: SSN OR UW ID #:	
WERE ANY OF THE FOLLOWING CONTACTED: Y=Yes N=No (Check All That Apply)				
SUPERVISOR: \[\supervisor \color \supervisor \color \col				
WHAT HAPPENED TO THE INJURED PARTY: ☐ First Aid Administered ☐ Refused Treatment/Transport ☐ Left With Friend ☐ Transported to Hospital ☐ Returned to Work ☐ Went Home ☐ Went to Physician ☐ Unknown				
SECTION B PERSONAL INJURY				
if the injured person is a University employee a separate workers' compensation report must be made to human resources				
Part of Body Injured: Multiple Injuries:YN				
Cause of Any Injury (check all that apply):				
□Slip/Fall □ Classroom/Laboratory Related □Burn □ Cut/Puncture/Scrape □ Strain/Overexertion □Slip/Fall on Ice				
☐ Slip/Fall on Stairs ☐ Repetitive Motion Injury ☐ Other				

Weather Condition(if outdoors):				
Witness Name(s): Con	tact Info:			
Witness Name(s): Contact Info:				
WAS INJURY A RESULT OF THE USE A MOTOR VEHICLE: YES NO (If yes, complete Section C)				
SECTION C AUTO ACCIDENT ONLY				
DRIVER/VEHICLE INFORMATION				
Name of Insured (for the reporting party): Department:	Name of Other Driver: Driver's License Number:			
Driver's License Number:				
DOB:/ State:	DOB:/ State:			
Description of Vehicle: License Plate Number:	Description of Vehicle: License Plate Number:			
Make: Model: Year: Color:	Make: Model: Year: Color:			
Owner:	Insurance Carrier:			
Any Injuries?:	Policy Number: Phone Number:			
Anto Accident Location Type: Intersection City Street Highway Parking Lot Other Type of Accident: Collision Involving Oth Collision With Stationa Roll Over Collision With Bicycle/	ry Object			
Section D Property Damage				
Cause of Damage(s): □ Vandalism □ Wind	Building/Property Secured: ☐Yes ☐No			
Facility Manager: Contact Info: P				
	fo:			
Witness Name(s): Contact In:	fo:			