

THIS IS NOT A WORKERS' COMPENSATION REPORT

If this is an injury, have you filled out a workers' compensation form? ☐ Yes ☐ No

PERSONAL INFORMATION	
Today's Date	UW#:
First Name:	Last Name:
Email:	Phone Number:
Alt. Phone Number:	

PRINCIPAL INVESTIGATOR/ SUPERVISOR (include contact information such as email or phone number)
Name:
Name:

INCIDENT INFORMATION	
Pathogen working with:	
Does the pathogen contain recombinant DNA or synthetic nucleic acid molecules? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Location (building, room):	Date and Time of Incident:
Incident Type (exposure, physical injury, etc.):	
Incident Description (provide as much detail as possible and list external events that may have contributed to the incident):	

METHOD AND LOCATION OF INJURY (CHECK ALL THAT APPLY) :	
Method: <input type="checkbox"/> Needlestick <input type="checkbox"/> Blood or body fluids <input type="checkbox"/> Spill <input type="checkbox"/> Aerosol <input type="checkbox"/> Animal Bite/Scratch <input type="checkbox"/> Necropsy <input type="checkbox"/> Broken Glass <input type="checkbox"/> Sharps Container <input type="checkbox"/> Other (describe):	Location on body:
Action(s) taken to control incident (e.g. hand washing, spill clean-up, etc.):	

PERSONAL PROTECTIVE EQUIPMENT (PPE) WORN AT TIME OF INJURY	
<input type="checkbox"/> Lab Coat <input type="checkbox"/> Scrubs <input type="checkbox"/> Surgical Gown <input type="checkbox"/> N-95 respirator mask <input type="checkbox"/> Gloves Type of glove(s): _____ <input type="checkbox"/> Hair Cover	<input type="checkbox"/> Tyvek <input type="checkbox"/> PAPR <input type="checkbox"/> Face Shield <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Goggles <input type="checkbox"/> Shoes
Was there a PPE Failure? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, explain:	

Fill out form, send PDF copy to biosafety@uwyo.edu. Contact Biosafety Specialist with questions at 307-766-2723.