

**UNIVERSITY OF CALIFORNIA, BERKELEY
OFFICE OF RISK MANAGEMENT
ACCIDENTAL INJURY REPORT**

INSTRUCTIONS: Prepare this report for ANY non-work related injury which MAY require first aid or medical attention. Return the completed form immediately to the *Office of Risk Services, 2130 Center Street, Mail Code 4208 or fax to 510-643-0281.*

Name of Injured: _____ Age: _____
Address: _____ Telephone: _____

Gender: Male _____ Female _____

Status: Student _____ Employee _____ Visitor _____

Date of Accident: _____ Time of Day: _____ A.M./P.M.

Person in Charge of Area or Activity: _____

UC Police Called? Yes _____ No _____ Person Refused Call to Police _____

Was Injured Person Transported to a Hospital? Yes__ No__ If yes, name of hospital _____

DETAILS OF ACCIDENT: Please describe fully the location of the accident, the circumstances under which it occurred, conditions (environment, weather, etc.) that might have been a factor, and whether tools, instruments, or other people were involved. (On the reverse side, please diagram the location of the accident.)

DESCRIPTION OF INJURY: Please describe the nature of the injury (specify part of the body injured).

DESCRIPTION OF ASSISTANCE RENDERED: Please indicate any first aid measures provided prior to treatment at a medical facility.

Name of reporting department: _____

This report prepared by _____

Date: _____

Campus Address: _____

Phone: _____

This report reviewed by (Department Representative)_____

Reviewer's Campus Address:_____ Phone_____

Date:_____