**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 Suite 200, Mail Code 4208 or fax to 510-643-0281.*

Name of Injured:_____Age:_____

Address:_____ Telephone: _____

Gender Identity: _____

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:_____