

**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, 2199 Addison St. Suite 615, Berkeley, CA 94720. Mail Code: 1120 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: \_\_\_\_\_