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:_____