WEBER STATE UNIVERSITY

Environmental Health & Safety

Individual Report of Incident

☐ Check if this is a bloodborne exposure (needlestick, contact with blood through eye, mouth, mucous membrane, etc.)

Employee Information

1. Date of Injury, Illness, or Exposure	2. Time of Injury, Illness, or Exposure	3. Last Name, First, MI
4. Employee phone	5. W#	6. Employee email
7. Home Address	City, State, Zip(*MUST include home zip code)	
8. Date of birth ___/___/_____	9. Sex ☐ Male ☐ Female ☐ Unknown	10. Number of Dependents

Employment Info

11. Work Phone	12. Occupation/Job Title	13. Date hired
14. Employment Status ☐ Full Time ☐ Seasonal ☐ Part Time ☐ Volunteer ☐ Intern ☐ Student Hourly	15. Wage Range	16. Number of days worked per week

Injury

17. Time of Injury/Illness/Exposure (if known)	18. Date Employer was Notified	19. Time shift began

Occurrence

20. Accident Premises ☐ Employer Premise ☐ Worksite/Jobsite/Clinical Site ☐ Not Premise or Jobsite (other) ☐ Employee Residence	21. Accident Location (Address, city, state, zip, ***or*** building name/room number, ***or*** outdoor area name)

Injury/Illness/Exposure Info

22. Region of body (e.g., head, torso, lower extremities)	23. Part of body (e.g., face, chest, shin)	
24. Type of injury/illness/exposure (break, sprain, laceration, burn, etc.)	25. Side of body (left, right, bi-lateral, unknown)	
26. Cause of injury/illness/exposure (be specific)	27. Was safety equipment provided? ☐ Yes ☐ No	28. If yes, was it used? ☐ Yes ☐ No
29. List all safety equipment/PPE used at time of injury.	30. Describe injury and how it occurred (be specific):	

	31. Specific activity employee was engaged in when the accident or illness occurred (be specific, use separate sheet of paper or form if needed):	
	32. Equipment, materials, chemicals employee was using when accident occurred:	
	33. Work process employee was engaged in when accident or illness occurred:	
	34. If this was a bloodborne exposure, what was the route of exposure (needlestick, splash, non-intact skin, mucous membrane, etc.)	35. If this was a bloodborne exposure, what device was used? (needle, lancet, splash, etc.)
Treatment	36. Initial Treatment ☐ No treatment; or Date of treatment_____ ☐ Emergency Care ☐ Hospitalized for more than 24 hours ☐ Major medical/lost time anticipated ☐ Minor - by clinic/hospital ☐ Minor - by employer	37. Physician Info (Name, address, city, state, zip, phone): 38. Care facility information (hospital/clinic, address, city, state, zip, phone):
Other	39. Witness (name, phone, email, title)	
Misc.	40. Supervisor's Name	41. Supervisor's Email & Phone #
	Signature	Date / Time

Supervisor or Clinical Instructor:
Print and complete this form **only if the exposed individual refuses post-exposure medical evaluation by a health care professional.** Send this completed form to hr@weber.edu

I have been fully trained in WSU's Exposure Control Plan, and I understand I may have contracted an infectious disease such as HIV, HCV, or HBV. I also understand the implications of contracting these diseases.

I have been offered follow-up medical testing free of charge by my employer to determine whether or not I have contracted an infectious disease such as HIV, HCV, or HBV. I have also been offered follow-up medical care in the form of counseling and medical evaluation of any acute febrile illness (new illness accompanied by fever) that occurs within twelve weeks post-exposure.

Despite all the information I have received, for personal reasons, I freely decline this postexposure evaluation and follow-up care.

Exposed Individual's Signature: _____

Date: _____

Witness Name: _____

Witness Signature: _____