

Please fill in all Required fields. If a field doesn't apply, please type in 'N/A'.

Person completing form: Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Date incident occurred: \_\_\_\_\_ Time: \_\_\_\_\_ Date employer was notified: \_\_\_\_\_ Who notified? \_\_\_\_\_

**PART A: COMPLETE THIS PART OF FORM FOR ALL INCIDENTS**

Injured/Involved person: Last name: \_\_\_\_\_ First name: \_\_\_\_\_ EMPLID: \_\_\_\_\_  
 Local address (include city, state, zip code): \_\_\_\_\_ Phone: \_\_\_\_\_  
 Sex:  Female  Male Marital Status: \_\_\_\_\_ Name of parent/guardian (if under 18): \_\_\_\_\_  
 Injured/Involved person's relationship to UND:  Employee/Student Employee  Student (non-employee)  Visitor  
 Was injury/illness work related?  Yes  No Employing Department: \_\_\_\_\_  
 Supervisor: \_\_\_\_\_ Supervisor's email: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Job title of injured person: \_\_\_\_\_  Part-time  Full-time  
 Address, building name, or location of incident: \_\_\_\_\_  
 Was the incident:  Inside  Outside If Outside:  Clear  Raining  Snowing  Other \_\_\_\_\_  
 Description of incident: \_\_\_\_\_

**Injury and illness information:**

No apparent injury or illness (Skip to Part C)  
 Slight injury or illness not requiring professional medical attention Body part(s) injured: \_\_\_\_\_  
 Injury or illness requiring professional medical attention  
 (If third box is checked, complete Part B)  
 Time lost from work (number of days and/or hours): \_\_\_\_\_  
 Witness (es) to incident: \_\_\_\_\_

Names

Phone

**PART B: COMPLETE THIS PART ONLY IF INJURY OR ILLNESS REQUIRED MEDICAL ATTENTION**

Medical facility: \_\_\_\_\_ Physician: \_\_\_\_\_ Date of initial treatment: \_\_\_\_\_  
 Description of medical treatment (s): \_\_\_\_\_

**NOTE: Please call Office of Safety 701.777.3341 with your Social Security Number & Date of Birth as both are needed to file a claim**

**PART C: COMPLETE THIS PART ONLY IF INCIDENT INVOLVED LOSS OR DAMAGE TO PROPERTY**

**Property/Vehicle/Equipment Loss or Damage**

What was lost or damaged? \_\_\_\_\_  
 Owner of damaged or lost property: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Owner's address: \_\_\_\_\_  
 Was any State property lost or damaged?  Yes  No  
 Where can the damaged property be seen? (Attach photo if possible) \_\_\_\_\_  
 What could be done to prevent a reoccurrence of this incident? \_\_\_\_\_

The above information on this report is accurate based on my knowledge of the incident,

Click here to send this form to Office of Safety. You can also save and email it to [und.safety@email.und.edu](mailto:und.safety@email.und.edu) and your Supervisor

Signature \_\_\_\_\_ Date \_\_\_\_\_

Route to:

Supervisor's signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Office of Safety \_\_\_\_\_ Date \_\_\_\_\_

**NOTIFY OFFICE OF SAFETY IMMEDIATELY (WITHIN 24 HOURS) FOR ALL INCIDENTS RESULTING IN PERSONAL INJURY**

**OFFICE OF SAFETY: 3851 Campus Rd. Stop 9031 Grand Forks, ND 58202**

**Tel: 701.777.3341 Fax: 701.777.4132 Email: [und.safety@email.und.edu](mailto:und.safety@email.und.edu)**