## Incident Report Form

**Date of Incident:**

**Time:** *(AM/PM)*

### Information of the Injured Person

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone Number(s):</th>
<th>Date of Birth:</th>
<th>Male ☐ Female ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Who was injured?***circle one***

- Visitor
- Researcher
- Research Participant

**Type of Injury:**

**Location of the Injury:** *(e.g. corridor, computer lab, MRI suite)*

**Did the injury or illness involve any of the following:** *(check all that apply)*

- Head
- Hand *(R)/(L)*
- Foot *(R)/(L)*
- Eye *(R)/(L)*
- Arm *(R)/(L)*
- Leg *(R)/(L)*
- CPR
- AED
- Bleeding
- Fall
- Burn
- An electrical shock
- Poisoning

**Describe the accident:**

**What actions were taken?**

**Did the injury require physician or hospital visit?**

- Yes ☐
- No ☐

**Signature of Person Completing Form:**

**Date:**

**Print your Name:**

**Witnesses:**

*Return this form to the Research Technologist within 24 hours of incident.*