



THE UNIVERSITY OF TEXAS AT TYLER
Accident and Injury Report
For Students and Visitors (in non-work related injuries)

If you are a student or a visitor (involved in a non-work related injury), complete this form and email it to safety@uttyler.edu or FAX it to the Environmental Health and Safety Department at **903-565-5829**.

1. Status: <input type="checkbox"/> Student <input type="checkbox"/> Visitor	2. Date of injury/illness: (M/D/YY)	3. Time of injury/illness <input type="checkbox"/> AM <input type="checkbox"/> PM																																																																																	
4. Name: (Last, First, MI)																																																																																			
5. Address:	a. Phone #:	b. E-Mail Address:																																																																																	
6. Medical attention requested: <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																			
7. Address or location where injury or exposure occurred. <input type="checkbox"/> Main Campus <input type="checkbox"/> Longview University Center <input type="checkbox"/> Palestine Campus																																																																																			
8. Injury Location:	Building	Floor	Room Number																																																																																
9. Brief Description of what happened:																																																																																			
11. Cause of injury/illness (e.g., slip or fall, chemical, etc.):																																																																																			
Body Part Effected																																																																																			
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:5%;">X</th> <th style="width:75%;">Mark Appropriately</th> <th style="width:10%;">R</th> <th style="width:10%;">L</th> </tr> </thead> <tbody> <tr><td></td><td>Head</td><td></td><td></td></tr> <tr><td></td><td>Face</td><td></td><td></td></tr> <tr><td></td><td>Neck</td><td></td><td></td></tr> <tr><td></td><td>Chest</td><td></td><td></td></tr> <tr><td></td><td>Stomach</td><td></td><td></td></tr> <tr><td></td><td>Back (lower)</td><td></td><td></td></tr> <tr><td></td><td>Back (upper)</td><td></td><td></td></tr> </tbody> </table> <table border="1" style="width:45%; margin-left: 20px; border-collapse: collapse;"> <thead> <tr> <th style="width:5%;">X</th> <th style="width:75%;">Mark Appropriately</th> <th style="width:10%;">R</th> <th style="width:10%;">L</th> </tr> </thead> <tbody> <tr><td></td><td>Eye</td><td></td><td></td></tr> <tr><td></td><td>Shoulder</td><td></td><td></td></tr> <tr><td></td><td>Arm</td><td></td><td></td></tr> <tr><td></td><td>Hand</td><td></td><td></td></tr> <tr><td></td><td>Finger</td><td></td><td></td></tr> <tr><td></td><td>Wrist</td><td></td><td></td></tr> <tr><td></td><td>Leg</td><td></td><td></td></tr> <tr><td></td><td>Knee</td><td></td><td></td></tr> <tr><td></td><td>Ankle</td><td></td><td></td></tr> <tr><td></td><td>Foot</td><td></td><td></td></tr> <tr><td></td><td>Toe</td><td></td><td></td></tr> </tbody> </table>				X	Mark Appropriately	R	L		Head				Face				Neck				Chest				Stomach				Back (lower)				Back (upper)			X	Mark Appropriately	R	L		Eye				Shoulder				Arm				Hand				Finger				Wrist				Leg				Knee				Ankle				Foot				Toe		
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12. Doctor/Hospital Name/Address/Phone#:																																																																																			
13. EMS Decision: <input type="checkbox"/> Transport <input type="checkbox"/> No Transport																																																																																			
14. Patient Decision: <input type="checkbox"/> Transport <input type="checkbox"/> No Transport																																																																																			
15. Witness Contact Information:																																																																																			

INFORMATION RELEASE

By signing this report form, I understand that I am giving my authorization to The University of Texas at Tyler designated database custodians to use and/or disclose my protected health information for the purpose of reviewing the accident/injury reported.

Signature: _____ **Date:** _____

Date Received by EHSD Office _____ **Initials:** _____