Student Accident/Injury Report

Name	**SBU ID**	
Address	**City/State**	**Zip**
Home Telephone	**Cell Telephone**	
Date of Birth	**Gender: __ Female __ Male**	
Date of Accident	**Time of Accident __AM __ PM**	
Accident *(be specific)* Bldg: Department:	**Lab Room #** **PI/Supervisor:**	
Type of Injury/Illness (e.g., cut, sprain, chem. splash)	**Body Part Injured**	
Medical Attention Required: ☐ YES ☐ NO	**Seen By: ☐ Private MD ☐ Hospital ED** **☐ Student Health Services** **☐ Other:**	
Medical Treatment Rec'd:		
Provider Name	**Address**	
Describe the accident (how did it occur, what was the result, etc.):		
Student Signature	**Date**	
Eyewitness Statement:		
Eyewitness Name (print)	**Eyewitness Signature**	**Date**
Supervisor or PI Statement:		
What do you think can be done to prevent this from reoccurring?		
Was Parent/Guardian Called: ☐ Yes – spoke with person - Name: **☐ Left Message - Date: Time: ☐ No. Was not able to reach anyone.**		
Supervisor/PI Name (print)	**Supervisor/PI Signature**	**Date**

Use the back of this form or additional pages if more space is needed
THIS FORM MUST BE COMPLETED AND SENT TO EH&S WITHIN 3 DAYS OF THE ACCIDENT/INJURY
Send copy of form to Environmental Health & Safety FAX: 632-9683 or Zip=6200
KEEP A COPY OF THIS FORM IN THE LABORATORY FILES