INCIDENT/ACCIDENT REPORT
(Other than Motor Vehicle or Employee/Volunteer Injury)

STD. 268 (CSUMB REV. 8-18)

Injury/Illness, Damage on Campus or at a University Activity

This report should be completed and distributed within 48 hours of the incident. Attach any photos, maps, additional pages or diagrams.

CONFIDENTIAL--ATTORNEY/CLIENT PRIVILEGED DOCUMENT

This is a CONFIDENTIAL report to provide information for use by legal counsel in the event a claim is filed against the State or its employees. Under no circumstances should information be given to anyone except authorized state officials.

INJURY TO EMPLOYEE OR REGISTERED VOLUNTEER: CONTACT WORKERS' COMP AT 831-582-3584

INCIDENT DATE : _____ TIME:	**POLICE NOTIFIED?** ☐ YES ☐ NO	**LOCATION** (Describe specific location of the incident. If needed, attach maps and mark location.)	☐ CSUMB STUDENT ☐ VISITOR

INJURED PARTY INFORMATION

INJURED PARTY'S NAME (Last, First, M.I.)	**BIRTH DATE**	**TELEPHONE NUMBER** ( )

DESCRIBE HOW THE INJURY OCCURRED:

TYPE OF INJURY (check box)**:**

- ☐ Reaction to foreign substance/objects
- ☐ Puncture
- ☐ Laceration
- ☐ Contusion
- ☐ Burn
- ☐ Fracture
- ☐ Amputation
- ☐ Sprain/Strain
- ☐ Other _____

PART OF BODY (check box)**:**

☐ Head	☐ Face	☐ Eye	☐ Groin
☐ Ear	☐ Mouth	☐ Neck	☐ Other: _____
☐ Heart	☐ Trunk	☐ Back	
☐ Shoulder	☐ Elbow	☐ Wrist	_____
☐ Finger	☐ Hip	☐ Leg	
☐ Knee	☐ Ankle	☐ Toe	_____

_____

PHOTOGRAPHS TAKEN? ☐ YES ☐ NO

IF YES, BY WHOM _____

FIRST AID / MEDICAL TREATMENT GIVEN? ☐ YES ☐ NO

IF YES, BY WHOM _____

WITNESS INFORMATION

NAME (Last, First, M.I.)	**TELEPHONE NUMBER**
1.	( )
2.	( )

DEPARTMENT REPORTING INCIDENT/ACCIDENT

CAMPUS OFFICE, DEPARTMENT, PROGRAM NAME:

EMPLOYEE'S NAME AND TITLE:	**TELEPHONE NUMBER** ( )
EMPLOYEE'S SIGNATURE	**POSITION/TITLE**
EMPLOYEE'S SUPERVISOR'S NAME AND TITLE:	**TELEPHONE NUMBER** ( )

DISTRIBUTION: ORIGINAL—RISK MANAGEMENT OFFICE, Mt. Hall, Ste., B
COPY—Scan (take photo if necessary) IMMEDIATELY TO: risk@csumb.edu and call: University Police Department (UPD)- if emergency: 9-1-1 or 831-655-0268
COPY--RETAINED BY REPORTING DEPARTMENT, COLLEGE/DIVISION/PROGRAM OFFICE

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USE ADDITIONAL SHEETS AS NECESSARY

WAS THIS A CLASS, FIELD TRIP, FREETIME, LAB, LECTURE, OTHER? Please describe in detail.

WERE THERE TOOLS, MATERIALS (CHEMICALS, COMPRESSED GAS, ETC), OR EQUIPMENT IN USE DURING THIS TIME? Please describe in detail.

WAS THERE SAFETY EQUIPMENT IN USE? ☐ YES ☐ NO

If "yes" please specify:

WAS SAFETY TRAINING PROVIDED PRIOR TO INCIDENT? ☐ YES ☐ NO

If "yes" please describe:

DESCRIBE ANY CONDITIONS (INSIDE OR OUTSIDE) THAT MAY HAVE CONTRIBUTED TO THE INJURY:

WAS THERE A RELEASE AGREEMENT SIGNED BEFORE THE ACTIVITY? ☐ YES ☐ NO

If "yes" please send the release with this report to Risk Management Office – Building 1, Room 128

PROPERTY DAMAGE/LOSS INFORMATION

PROPERTY OWNER'S NAME (Last, First, M.I.)	**TELEPHONE NUMBER**	☐ **CSUMB STUDENT**
	( )	☐ **FACULTY/STAFF**
		☐ **VISITOR**

NATURE AND EXTENT OF DAMAGE / LOSS (Describe in detail):

UNIVERSITY EMPLOYEES, (FACULTY, STAFF, STUDENT ASSISTANT, UNIVERSITY VOLUNTEER,) CORPORATION AND/OR ASI EMPLOYEES ARE TO REPORT INJURIES TO THEIR SUPERVISOR, REQUEST AND COMPLETE WORKERS COMPENSATION REPORT OF INJURY FORM FROM THEIR PERSPECTIVE EMPLOYERS, AND RETURN IT TO THE APPROPRIATE UNIVERSITY PERSONEL DEPARTMENT.