CUSTOMER/VISITOR REPORT OF INJURY

THIS REPORT SHOULD BE COMPLETED WHEN ANY INJURY OCCURS ON STATE OWNED OR CONTROLLED PROPERTY. THIS REPORT SHOULD BE COMPLETED AND SUBMITTED TO THE RISK MANAGEMENT DIVISION WITHIN 24 HOURS.

Please make no comment regarding liability, fault or blame.

Customer/Visitor information:

1. Name: _____
(Please include parent or guardian's name if the injured is a minor)

2. Mailing Address: _____
(Street) (City) (State) (Zip)

3. Daytime Telephone Number: _____ 4. Evening Telephone Number: _____

5. Controlling Dept/Agency where injury occurred: _____

6. Date of Injury: _____ 7. Time of Injury: _____

8. Where Injury Occurred: _____
(address, city & state)

9. Describe fully ***what*** injury occurred (mention body part(s) affected) and explain ***how*** and exactly ***where*** the injury occurred: _____

10. Witnesses to injury: Name: _____ Telephone Number: _____

11. Injury resulted in what treatment at the site: First Aid _____ Ambulance/paramedics _____
Other, specifically _____

12. What factors, events and/or conditions contributed to the incident? _____

13. Did the customer/visitor express any concern about the incident? Yes _____ No _____
If Yes, what was mentioned: _____

14. Name and title of person completing this report: _____
Date: _____ Time: _____

Signature: _____ Telephone Number: _____