

Dickinson College		Injury / Illness Report				Incident Tracking Number:										
Carlisle, Pennsylvania		Completed by Injured Employee, Supervisor, Dept. Director, Public Safety				Assigned by Human Resources										
Incident Information					Subject's Relationship to the College Mark all that apply <input checked="" type="checkbox"/>											
Day		Date		Time		Employee		Faculty		Full Time						
Location					Dickinson Student		Administrator		Part Time							
Related or Affected Department					Visitor / Guest		Support Staff		Casual							
					Other		Student Worker									
Subject's Information																
Name				Male		Female		DOB		SSN						
Residence			Contact				Employer *		Dickinson		Other					
Street				Telephone, Home												
				Telephone, Mobile / Cell												
City				e-mail, Home												
State		Zip Code		Other		Telephone, Work										
				e-mail, Work												
* If Dickinson College employee note Department, Supervisor & Job Title.					Secondary Employment?		Yes		No	If yes, specify on attached page						
Employer Notified		Date		Time		Supervisor Notified		Date		Time						
Injury / Illness Information																
					N/A											
Nature of Injury Mark all that apply <input checked="" type="checkbox"/>					Body Part(s) Injured Mark all that apply <input checked="" type="checkbox"/>											
Hearing Loss		Abrasion		Contusion		Fracture		Abdomen		Eye		Hip		Shoulder		
Poisoning		Amputation		Cut-laceration		Hernia		Ankle		Finger		Knee		Skin		
Respiratory Condition		Bruise		Death/Fatality		Infection		Arm, upper		Foot		Leg		Thigh		
		Burn, chemical		Dermatitis		Needle stick		Back		Forearm		Lungs		Thumb		
Skin Disorder		Burn, thermal		Dislocation		Puncture wound		Chest		Groin		Multiple		Toe		
Other Illness		Concussion		Electrical shock		Sprain / Strain		Ear		Hand		Neck		Wrist		
Other Injury		Carpal tunnel		Eye injury				Elbow		Head		Other				
Treatment Mark all that apply <input checked="" type="checkbox"/>																
N/A Not needed					No Medical Care on scene		*If Subject is deceased, date of death:									
Requested by Subject					Self Care on scene		Treated on Scene by DPS		Clinic / Hospital							
Recommended					First Aid provided on scene		Treated on Scene by EMS		College Health Center							
Provided					Non-Emergency care		Transported by Self		Panel Physician							
Refused by Subject					Emergency Medical care		Transported by DPS		Subject's Physician							
					Emergency Medical care		Transported by EMS		Emergency Department							
If transported to clinic, hospital or physician, where?				Carlisle Regional Medical Center			U.S. Health Work's		Other							
If other, where?																
Safety Information Personal Protective Equipment (PPE)																
PPE Type					N/A		PPE Available?		Yes		No	PPE Used?		Yes		No
Subject's activity at time of incident?																
Conditions in area? (Clothing worn; weather, lighting, surfaces...)																
Description of incident (Attach additional pages if needed)																
If injured, what is the specific nature of the injury?																
Describe any object or substance that may have directly harmed the subject.																
N/A																
Witness(es) to incident																
None					(Attach additional pages if needed)											
Name			Address				Contact (Telephone, e-mail)									
DPS Notified		Yes		No	Person completing Report (Name & Title, Contact Telephone Number)					Date Completed						