



Accident Report

Important: Email copy to:
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(859) 256-3323

Form FM84
03/08/2019

Date of Occurrence _____

Time of Occurrence _____

Section A: Personal Information

Name: _____ Student Employee Visitor EE/Student ID: _____

Facility/Campus: _____

Accident Location: _____

Section B: Description of Injury

Apparent Nature of Injury

- | | | |
|---------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Concussion | <input type="checkbox"/> Puncture |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Cut | <input type="checkbox"/> Scald |
| <input type="checkbox"/> Asphyxiation | <input type="checkbox"/> Dislocation | <input type="checkbox"/> Scratch |
| <input type="checkbox"/> Bite | <input type="checkbox"/> Fracture | <input type="checkbox"/> Shock |
| <input type="checkbox"/> Bruise | <input type="checkbox"/> Laceration | <input type="checkbox"/> Sprain |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Poisoning | <input type="checkbox"/> Other |

If Other, explain: _____

Part of Body Injured

- | | | |
|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Elbow L <input type="checkbox"/> R <input type="checkbox"/> | <input type="checkbox"/> Head |
| <input type="checkbox"/> Ankle L <input type="checkbox"/> R <input type="checkbox"/> | <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> | <input type="checkbox"/> Knee L <input type="checkbox"/> R <input type="checkbox"/> |
| <input type="checkbox"/> Arm L <input type="checkbox"/> R <input type="checkbox"/> | <input type="checkbox"/> Face | <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> |
| <input type="checkbox"/> Back | <input type="checkbox"/> Finger | <input type="checkbox"/> Mouth |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> | <input type="checkbox"/> Other |
| <input type="checkbox"/> Ear L <input type="checkbox"/> R <input type="checkbox"/> | <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> | |

If Other, explain: _____

Describe the nature of the injury (cut, third finger, left hand, etc.): _____

Describe medical attention provided or received and by whom: _____

If **employee** was injured, were they hospitalized **for treatment**? Yes No If yes, was OSHA notified? Yes No

Section C: Description of Accident

Did accident occur while in an instructional or work activity? Yes No If no, continue to Section D.

Please specify any machine, equipment, or tools involved: _____

If applicable, were proper machine guards used? Yes No

Was individual using Safety Equipment? Yes No Describe Safety Equipment: _____

If Safety Equipment was not in use, explain: _____

Was individual given safety orientation? Yes No

Was this accident/injury due to faulty equipment? Yes No

Did person have permission to use equipment? Yes No If no, explain: _____

Was supervisor/instructor present at accident? Yes No If no, explain: _____

Describe any action taken to prevent recurrence: _____

Section D: Statements/Signatures

Employee's/Student's/Visitor's description of accident (explain in detail):

Employee's/Student's/Visitor's Signature: _____ Date _____

Was family notified? Yes No Explain: _____

For Student Use Only - Was student provided with AG supplemental insurance form? Yes No

Witness' description of accident (explain in detail):

Witness' Signature: _____ Date _____

List all non-student/non-supervisor witnesses and contact information:

Name	Email Address	Phone Number

Supervisor's/Instructor's description of accident (explain in detail):

Supervisor's/Instructor's Name and Signature _____ Date _____

Section E: Additional Signatures

If report is completed by an individual other than the Supervisor/Instructor please provide name and signature below:

Name and Signature _____ Date _____

Section F: Administrator Comments:

Administrator's Signature: _____ Date _____

Section G: KCTCS Environmental Health and Safety Review

Date accident report received by EHS Coordinator: _____

FOR SAFETY SECTION USE ONLY		
Degree of Injury	Minor	Severe