INCIDENT REPORT FORM INSTRUCTIONS

Use the Incident Report Form to report campus incidents and employee work related injuries. These incidents may include, but are not limited to, slips and falls, laboratory events, needlestick injuries, and/or other incidents that may require medical assistance. This form should be completed and submitted as soon as possible following an incident, but no later than 24 hours following the event.

DIRECTIONS:

- Complete each section of the form as applicable, depending on whether the injured person falls into the **Employee**, **Student** or **Other** category.
- Answer all questions to the best of your ability.
- Provide the date and time of the occurrence and the date you completed this form.
- Use the Pull down Menu in the select boxes, as indicated. (e.g., Campus Location and Building Name)
- Provide the full proper name (e.g., name as printed on Driver's license) of the individual involved in the incident.
  - NOTE: If there is more than one individual involved, a completed form is required for each individual.
- STUDENTS are required to provide their Banner ID # as well as their insurance carrier's name.
- Individuals who are not employees or students are required to provide:
  - Occupation and name of employer.
  - Health insurance carrier.
  - Reason you are on campus.
- Provide a brief description of the incident and an indication of the body part affected by this incident.
- If the incident was a needlestick/sharp/bloodborne pathogens exposure event, check the **YES** box and provide specific information on the brand and device.
- If the incident was a needlestick/sharp/bloodborne pathogens exposure incident, ***you are also required to complete the Bloodborne Pathogens Report Form (attached to the incident form).***
- Enter the name, phone number and home address of each person who witnessed the incident.
- The individual who is the subject of the Incident Report Form must sign at the bottom. By signing the form, you attest that the information provided is correct to the best of your knowledge.
- The signature of the employee's supervisor, or university representative for non-employees, must be provided.
  - PLEASE NOTE: SIGNING THIS FORM IS NOT AN ADMISSION OF UNIVERSITY LIABILITY.

FINAL STEPS:

✓ Upon completion PRINT the form, sign, and SEND "original" to Risk Management and Insurance, 201 Mullica Hill Road Glassboro, NJ 08028.

✓ After Printing, save document to your desktop and email, as an attachment, to incident-reports@rowan.edu

This form can be found on the Rowan University website at https://www.rowan.edu/incidentform

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INCIDENT REPORT FORM

Campus: Choose an item.	Date of Incident:	Time of Incident: ☐AM ☐PM	Date Form Completed:
Person Involved (Last Name, First Name, Middle Initial)	Date of Hire:	Date of Birth:	Sex: ☐Male ☐Female
Campus Address:		Campus Phone:	Department:
Home Address:		Home Phone:	Cell Phone:
Exact location of incident: Campus: Choose an item.		Building Name and Address: Choose an item	
Supervisor's Name:		Supervisor's Phone Number:	

EMPLOYEE (Check One) ☐Full Time ☐Part Time ☐Student Worker **EMPLOYEE** Shift Hours (e.g.: 8am-4pm):	Department Banner ID #: Job Title: 1. Was employee on duty? ☐Yes ☐No 2. Did individual require medical attention? ☐Yes ☐No 3. If YES to item #2, was individual transported to medical care? ☐Yes ☐No 4. If YES to item #2, was individual transported via: ☐Personal Vehicle ☐Ambulance ☐Other 5. Individual was transported to: ☐Wellness Center ☐E.R. ☐Occ. Health ☐Other 6. If YES to item #2, did the individual refuse medical care? ☐Yes ☐No 7. Was employee in his/her assigned area? ☐Yes ☐No 8. Did employee cease work due to incident ☐Yes ☐No 9. If YES to item #4, time work ceased? ☐AM ☐PM 10. If YES to item #4, date work ceased? 11. Is this a NEW injury? ☐Yes ☐No
STUDENT	1. Banner ID #: 2. Health Insurance carrier:
OTHER (Check One) ☐Vendor ☐Visitor ☐Volunteer ☐Other	1. Occupation/Employer: 2. Health Insurance carrier: 3. Reason for being on campus:
INCIDENT FACTS	1. Description of incident (state all facts clearly using individual's own words): 2. Body part affected/impacted: 3. Needlestick/Sharp/Bloodborne Pathogens Exposure Incident? ☐Yes ☐No If YES, complete both pages of the Bloodborne Pathogens Potential Exposure Addendum Form 4. If the incident involved equipment or a medical device, provide the name of the manufacturer, the name of the device/equipment and the serial number:
WITNESSES	1. Witnesses: a. Name: Home Phone Number: Address: b. Name: Home Phone Number: Address: c. Name: Home Phone Number: Address:

Signature of injured person By signing this form, the injured person certifies that the information provided is true to the best of their knowledge.	Signature of Employee's Supervisor or University Representative for Non-Employees PLEASE NOTE: SIGNING THIS FORM IS NOT AN ADMISSION OF UNIVERSITY LIABILITY

Supervisor: Did you agree with employee's verbal account of incident? ☐Yes ☐No If NO explain:

If you are required to complete the ***Bloodborne Pathogens Potential Exposure Form****, please scroll down and complete the addendum.*

Rowan University

BLOODBORNE PATHOGEN POTENTIAL EXPOSURE ADDENDUM

Person Involved (Last Name, First Name, Middle Initial)	
Banner ID #	Date of Incident:

Type of Incident:		
☐ Needlestick Injury	☐ Splash	☐ Bite
☐ Sharp Object Injury (Specify object):	☐ Other (Specify):	
Type of Fluid/Tissue:		
☐ Blood/blood product	☐ Visibly bloody body fluid	☐ Concentrated HIV
☐ Other body fluids	☐ Unknown	☐ Other (Specify):

What was the item that caused the injury, if applicable:			
☐ hollow bore needle	☐ Suture needle	☐ Syringe	☐ Scalpel
☐ Glass		☐ Other (specify):	
Needles size, if applicable:			
Manufacturer of device causing the injury:		Model:	
If device information is not known, provide the name and phone number of a person who could provide device information:			
Name:	Department:	Phone Number:	
If the item causing the injury was a needle or sharp medical device, did it have a safety design or protective mechanism?			
☐ Yes	☐ No	☐ Don't Know	☐ N/A
If Yes, type of safety device:			
☐ Shielded	☐ Retractable	☐ Blunted needles	☐ Other (specify):

Was the protective mechanism activated:				
☐ Yes , fully	☐ Yes, partially	☐ No	☐ Don't Know	☐ N/A

Did the exposure incident happen:			
☐ Before activation	☐ During activation	☐ Don't know	☐ N/A
If the item causing the injury was a needle or sharp medical device, did it have a safety design or protective mechanism?			
☐ Yes	☐ No	☐ Don't Know	☐ N/A
Was protective equipment used?			
☐ Latex gloves	☐ Face shield	☐ Lab coat/gown	☐ Goggles

☐ Respirator	☐ None	☐ Other (specify):
Where did the injury take place?		
☐ Autopsy/Pathology	☐ Clinical Laboratory	☐ Dialysis Unit
☐ Emergency Medical Services	☐ Emergency Room	☐ ICU/CCU
☐ Outpatient Clinic	☐ Operating Room	☐ Patient Room
☐ Service/Utility area	☐ Other (specify):	

Was the source patient known?	☐ Yes	☐ No	☐ N/A

The source patient was known positive for (check all that apply):				
☐ HBV	☐ HCV	☐ HIV	☐ Other (specify):	☐ None of the above

Was the injured worker the original user of the sharp item?			
☐ Yes	☐ No	☐ Don't Know	☐ N/A

For what purpose was the sharp item originally used:		
☐ Cutting	☐ Drilling	☐ Electrocautery
☐ Fingerstick/Heel Stick	☐ Heparin or saline flush	☐ Injection (IM, Subcutaneous, or other injection through the skin)
☐ Other injection into injection site or IV Port	☐ Suturing	☐ To connect IV line (Intermittent IV/Piggyback/IV infusion/Other IV line connection)
☐ To place arterial/central line *If used to draw blood was it a: ☐ Direct Stick ☐ Draw from line	☐ To draw venous blood sample	☐ To obtain body fluid or tissue sample (Urine/amniotic fluid/biopsy)
☐ To place an arterial or central line	☐ To start IV or Set up Heparin lock	☐ Unknown/Not applicable
☐ Other (specify):		

Describe the exposure incident:

How does the exposed person think this incident could have been prevented:

Was the injury (check one):	
☐ Superficial (little or no bleeding)	☐ Moderate (skin punctured, some bleeding)
☐ Severe (deep stick/cut or profuse bleeding)	☐ Mucous membrane contact
☐ Skin contact only	

Write the number (#) of the location of the injury (see picture to below):