



# STUDENT / VISITOR INJURY / ILLNESS REPORT

Case Number \_\_\_\_\_

## PART I - TO BE COMPLETED BY INJURED/ILL STUDENT/VISITOR (IF ABLE)

Name		CWID	Date of Birth	Phone Number
Street		City		State      Zip
Home Phone Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Department or Sponsoring Organization		<input type="checkbox"/> Student <input type="checkbox"/> Visitor CSU Student ID (If Applicable):
Activity During Accident/Illness <input type="checkbox"/> Attending Class, Lab, etc. <input type="checkbox"/> Research <input type="checkbox"/> Field Trip <input type="checkbox"/> Club or Organization <input type="checkbox"/> Free Time <input type="checkbox"/> Other _____ Sports Activity <input type="checkbox"/> P.E. Class <input type="checkbox"/> Intramurals <input type="checkbox"/> Intercollegiate <input type="checkbox"/> Unsupervised Specific Sport _____      Name of Coach / Instructor Present _____ Medical Treatment Provided: <input type="checkbox"/> Yes <input type="checkbox"/> No      Returned to Activity: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Describe the injury/illness, including what, where, why, how the injury/illness occurred: _____ _____ _____				
Signature (If able)	Date	Report Completed By	Date	Phone Number

## PART II - TO BE COMPLETED BY INSTRUCTOR (WITHIN 24 HRS OF KNOWLEDGE OF INCIDENT)

Date of Injury / Illness / Death	Date of Knowledge of Injury	Time of Injury/Illness Hour _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
Describe the injury/illness, including what, where, why, how the injury/illness occurred: _____ _____ _____			
What has been done to correct any condition that might have contributed to the injury / illness? _____ _____			
What do you recommend for correction? _____ _____			
Part of Body (check) Indicate Right or Left when Applicable	Type of Injury (check)	Name of Witness / Dept / Phone#	
1. <input type="checkbox"/> Head    10. <input type="checkbox"/> Wrist    19. <input type="checkbox"/> Neck 2. <input type="checkbox"/> Face    11. <input type="checkbox"/> Hand    20. <input type="checkbox"/> Shoulder 3. <input type="checkbox"/> Eye    12. <input type="checkbox"/> Finger    21. <input type="checkbox"/> Groin 4. <input type="checkbox"/> Ear    13. <input type="checkbox"/> Knee    22. <input type="checkbox"/> No Injury 5. <input type="checkbox"/> Mouth    14. <input type="checkbox"/> Leg    23. <input type="checkbox"/> Other 6. <input type="checkbox"/> Heart    15. <input type="checkbox"/> Ankle 7. <input type="checkbox"/> Back    16. <input type="checkbox"/> Foot 8. <input type="checkbox"/> Trunk    17. <input type="checkbox"/> Toe 9. <input type="checkbox"/> Arm    18. <input type="checkbox"/> Hip	1. <input type="checkbox"/> Reaction to foreign substance/objects 2. <input type="checkbox"/> Puncture 3. <input type="checkbox"/> Laceration 4. <input type="checkbox"/> Contusion 5. <input type="checkbox"/> Burn 6. <input type="checkbox"/> Fracture 7. <input type="checkbox"/> Amputation 8. <input type="checkbox"/> Sprain/Strain 9. <input type="checkbox"/> Other	1.  2.  3.	
Coach / Instructor Signature	Department	Date	Extension
Department Head Signature	Title	Date	Extension