

Report of Accident or Incident Involving a Non-employee at UNT Health Science Center

1. LAST NAME OF INJURED		2. FIRST NAME		3. M.I.	
4. REASON FOR BEING ON CAMPUS			5. DATE AND TIME OF CAMPUS ACTIVITY		6. SPONSORING GROUP/CLINIC/DEPARTMENT
7. SEX <input type="checkbox"/> M <input type="checkbox"/> F	8. AGENCY 763	9. BUDGET NUMBER OF ASSIGNED UNIT	10. DATE OF INCIDENT		11. TIME OF INCIDENT (AM OR PM)

All sections to be completed by UNTHSC personnel except for section I which is completed by the injured person.

<p>A. EXTENT OF INJURY</p> <p><input type="checkbox"/> 01 Minor assistance given</p> <p><input type="checkbox"/> 02 Injured was ambulatory but went to clinic</p> <p><input type="checkbox"/> 03 Non-ambulatory went to clinic</p> <p><input type="checkbox"/> 04 Transported off campus Where: _____ by: _____</p> <p>B. CATEGORY (CHECK ONE ONLY)</p> <p><input type="checkbox"/> 01 Accident</p> <p><input type="checkbox"/> 02 Aggressive behavior</p> <p><input type="checkbox"/> 03 Person was ill</p> <p>C. SPECIFIC LOCATION OF OCCURRENCE (CHECK ONE ONLY)</p> <p>INDOORS:</p> <p>BUILDING INVENTORY NO. _____</p> <p><input type="checkbox"/> 01 Auditorium</p> <p><input type="checkbox"/> 02 Bath/Toilet area</p> <p><input type="checkbox"/> 03 Boiler room</p> <p><input type="checkbox"/> 04 Canteen/Snack bar</p> <p><input type="checkbox"/> 05 Cell block</p> <p><input type="checkbox"/> 06 Classroom</p> <p><input type="checkbox"/> 07 Closet</p> <p><input type="checkbox"/> 08 Day room</p> <p><input type="checkbox"/> 09 Dormitory/living room</p> <p><input type="checkbox"/> 10 Elevator</p> <p><input type="checkbox"/> 11 Food service area/dining/kitchen</p> <p><input type="checkbox"/> 12 Garage</p> <p><input type="checkbox"/> 13 Gymnasium/Recreation</p> <p><input type="checkbox"/> 14 Hallway/corridor</p> <p><input type="checkbox"/> 15 Hospital/clinic/dispensary</p> <p><input type="checkbox"/> 16 Laboratory</p> <p><input type="checkbox"/> 17 Laundry</p> <p><input type="checkbox"/> 18 Library</p> <p><input type="checkbox"/> 19 Nursing station</p> <p><input type="checkbox"/> 20 Office areas</p> <p><input type="checkbox"/> 21 Program areas</p> <p><input type="checkbox"/> 22 Ramp</p> <p><input type="checkbox"/> 23 Sales store/outlet</p> <p><input type="checkbox"/> 24 Seclusion room</p> <p><input type="checkbox"/> 25 Sleeping room</p> <p><input type="checkbox"/> 26 Steps/Stairs/Stairway</p> <p><input type="checkbox"/> 27 Storage area</p> <p><input type="checkbox"/> 28 Waiting room</p> <p><input type="checkbox"/> 29 Workshop/technical trades</p> <p><input type="checkbox"/> 30 Other (specify) _____</p> <p>OUTDOORS:</p> <p><input type="checkbox"/> 31 Athletic field</p> <p><input type="checkbox"/> 32 Campus</p> <p><input type="checkbox"/> 33 Grounds</p> <p><input type="checkbox"/> 34 Highway/road/street</p> <p><input type="checkbox"/> 35 Loading dock</p> <p><input type="checkbox"/> 36 Park or recreation area</p> <p><input type="checkbox"/> 37 Parking lot</p> <p><input type="checkbox"/> 38 Roof</p> <p><input type="checkbox"/> 39 Sidewalk</p> <p><input type="checkbox"/> 40 Steps/stairs/stairway</p> <p><input type="checkbox"/> 41 Storage</p> <p><input type="checkbox"/> 42 Swimming pool area</p> <p><input type="checkbox"/> 43 Tower</p> <p><input type="checkbox"/> 44 Other (specify) _____</p> <p>D. ACTIVITY ENGAGED IN BY INJURED AT TIME OF INJURY (CHECK ONE)</p> <p><input type="checkbox"/> 01 Bathing</p> <p><input type="checkbox"/> 02 Buffing</p> <p><input type="checkbox"/> 03 Carrying</p> <p><input type="checkbox"/> 04 Cleaning</p> <p><input type="checkbox"/> 05 Climbing</p> <p><input type="checkbox"/> 06 Cutting</p> <p><input type="checkbox"/> 07 Descending</p> <p><input type="checkbox"/> 08 Digging</p> <p><input type="checkbox"/> 09 Dressing</p> <p><input type="checkbox"/> 10 Driving</p> <p><input type="checkbox"/> 11 Eating</p> <p><input type="checkbox"/> 12 Escorting</p> <p><input type="checkbox"/> 13 Exercising</p> <p><input type="checkbox"/> 14 Feeding</p> <p><input type="checkbox"/> 15 Grinding</p> <p><input type="checkbox"/> 16 Grooming</p> <p><input type="checkbox"/> 17 Jumping</p> <p><input type="checkbox"/> 18 Lifting</p> <p><input type="checkbox"/> 19 Loading</p> <p><input type="checkbox"/> 20 Mopping</p>	<p>D. CONTINUED</p> <p><input type="checkbox"/> 21 Moving</p> <p><input type="checkbox"/> 22 Operating</p> <p><input type="checkbox"/> 23 Pulling</p> <p><input type="checkbox"/> 24 Pushing</p> <p><input type="checkbox"/> 25 Reaching</p> <p><input type="checkbox"/> 26 Redirecting</p> <p><input type="checkbox"/> 27 Restraining</p> <p><input type="checkbox"/> 28 Running</p> <p><input type="checkbox"/> 29 Sanding</p> <p><input type="checkbox"/> 30 Sawing</p> <p><input type="checkbox"/> 31 Searching</p> <p><input type="checkbox"/> 32 Securing</p> <p><input type="checkbox"/> 33 Sitting</p> <p><input type="checkbox"/> 34 Standing</p> <p><input type="checkbox"/> 35 Stripping</p> <p><input type="checkbox"/> 36 Turning</p> <p><input type="checkbox"/> 37 Walking</p> <p><input type="checkbox"/> 38 Welding</p> <p><input type="checkbox"/> 39 Other (specify) _____</p> <p>E. BODY PART INJURED (MOST SERIOUS)</p> <p><input type="checkbox"/> 01 Ankle</p> <p><input type="checkbox"/> 02 Arm</p> <p><input type="checkbox"/> 03 Back</p> <p><input type="checkbox"/> 04 Buttocks</p> <p><input type="checkbox"/> 05 Cheek</p> <p><input type="checkbox"/> 06 Chest</p> <p><input type="checkbox"/> 07 Chin</p> <p><input type="checkbox"/> 08 Ear(s)</p> <p><input type="checkbox"/> 09 Eye(s)</p> <p><input type="checkbox"/> 10 Foot-Feet</p> <p><input type="checkbox"/> 11 Finger/Thumb(s)</p> <p><input type="checkbox"/> 12 Forehead</p> <p><input type="checkbox"/> 13 Groin</p> <p><input type="checkbox"/> 14 Hand</p> <p><input type="checkbox"/> 15 Hip(s)</p> <p><input type="checkbox"/> 16 Internal organ</p> <p><input type="checkbox"/> 17 Jaw</p> <p><input type="checkbox"/> 18 Knee(s)</p> <p><input type="checkbox"/> 19 Leg(s)</p> <p><input type="checkbox"/> 20 Mouth</p> <p><input type="checkbox"/> 21 Neck</p> <p><input type="checkbox"/> 22 Nose</p> <p><input type="checkbox"/> 23 Pelvis</p> <p><input type="checkbox"/> 24 Rib(s)</p> <p><input type="checkbox"/> 25 Scalp</p> <p><input type="checkbox"/> 26 Shoulder</p> <p><input type="checkbox"/> 27 Toe(s)</p> <p><input type="checkbox"/> 28 Wrist(s)</p> <p><input type="checkbox"/> 29 Other (specify) _____</p> <p>F. TYPE OF INJURY (CHECK PRIMARY ONE)</p> <p><input type="checkbox"/> 01 Abrasion</p> <p><input type="checkbox"/> 02 Amputation</p> <p><input type="checkbox"/> 03 Bite</p> <p><input type="checkbox"/> 04 Bruise</p> <p><input type="checkbox"/> 05 Burn</p> <p><input type="checkbox"/> 06 Concussion</p> <p><input type="checkbox"/> 07 Cut</p> <p><input type="checkbox"/> 08 Dermatitis</p> <p><input type="checkbox"/> 09 Dislocation</p> <p><input type="checkbox"/> 10 Foreign object</p> <p><input type="checkbox"/> 11 Fracture</p> <p><input type="checkbox"/> 12 Frostbite</p> <p><input type="checkbox"/> 13 Hearing loss</p> <p><input type="checkbox"/> 14 Heart attack</p> <p><input type="checkbox"/> 15 Heat exhaustion</p> <p><input type="checkbox"/> 16 Hernia</p> <p><input type="checkbox"/> 17 Infection</p> <p><input type="checkbox"/> 18 Inflammation</p> <p><input type="checkbox"/> 19 Internal injuries</p> <p><input type="checkbox"/> 20 Puncture</p> <p><input type="checkbox"/> 21 Rupture</p> <p><input type="checkbox"/> 22 Scratch</p> <p><input type="checkbox"/> 23 Shock</p> <p><input type="checkbox"/> 24 Sprain</p> <p><input type="checkbox"/> 25 Sting</p> <p><input type="checkbox"/> 26 Strain</p> <p><input type="checkbox"/> 27 Other (specify) _____</p> <p>F-1. BLOODBORNE PATHOGEN EXPOSURE</p> <p><input type="checkbox"/> 01 Injury was not associated with exposure to bloodborne pathogen.</p> <p>Type of exposure:</p> <p><input type="checkbox"/> 02 needlestick with contaminated sharps</p> <p><input type="checkbox"/> 03 cut or picture with contaminated object (scalpel, etc.)</p> <p><input type="checkbox"/> 04 blood/body fluid splash to eyes</p> <p><input type="checkbox"/> 05 blood/body fluid splash to mouth</p> <p><input type="checkbox"/> 06 blood/body fluid on broken skin</p> <p><input type="checkbox"/> 07 other, specify _____</p> <p>Type of personal protective equipment (PPE) used:</p> <p><input type="checkbox"/> 08 Gloves</p> <p><input type="checkbox"/> 09 Gown</p> <p><input type="checkbox"/> 10 Eyewear</p> <p><input type="checkbox"/> 11 Mask</p> <p><input type="checkbox"/> 12 Resuscitation device</p> <p><input type="checkbox"/> 13 Sharps container/bag</p> <p><input type="checkbox"/> 14 Other (specify) _____</p> <p><input type="checkbox"/> 15 None. If none, why was none used (specify)? _____</p> <p>If PPE had safety feature, was it overridden or disengaged prior to use (i.e., click lock feature of vacutainer, etc.)</p> <p><input type="checkbox"/> 16 No</p> <p><input type="checkbox"/> 17 Yes. Explain _____</p> <p>G. TYPE OF OCCURRENCE (CHECK ONE ONLY)</p> <p><input type="checkbox"/> 01 Aggression (client, student, inmate, patient)</p> <p><input type="checkbox"/> 02 Bodily reaction (drug, medication)</p> <p><input type="checkbox"/> 03 Caught in, on, under or between</p> <p><input type="checkbox"/> 04 Contact with chemicals</p> <p><input type="checkbox"/> 05 Contact with electric current</p>	<p>G. CONTINUED</p> <p><input type="checkbox"/> 06 Contact with temperature extremes</p> <p><input type="checkbox"/> 07 Fall on same level</p> <p><input type="checkbox"/> 08 Fall on different level</p> <p><input type="checkbox"/> 09 Overexertion (exceeding physical ability resulting in strain, rupture)</p> <p><input type="checkbox"/> 10 Overexposure to environmental hazard (noise, toxic)</p> <p><input type="checkbox"/> 11 Slip (not a fall)</p> <p><input type="checkbox"/> 12 Struck against (rough, sharp object)</p> <p><input type="checkbox"/> 13 Struck by falling, moving object</p> <p><input type="checkbox"/> 14 Other (specify) _____</p> <p>H. PHYSICAL THING MOST CLOSELY ASSOCIATED WITH OCCURRENCE (CHECK ONE)</p> <p><input type="checkbox"/> 01 Aircraft</p> <p><input type="checkbox"/> 02 Air pressure</p> <p><input type="checkbox"/> 03 Animal (snake, dog, etc.)</p> <p><input type="checkbox"/> 04 Athletic equipment (baseball, bat, dart)</p> <p><input type="checkbox"/> 05 Attachments (belt, pulley, gear, shaft)</p> <p><input type="checkbox"/> 06 Building component</p> <p><input type="checkbox"/> 07 Cabinet</p> <p><input type="checkbox"/> 08 Chemical (solid, liquid, or gas)</p> <p><input type="checkbox"/> 09 Clothing</p> <p><input type="checkbox"/> 10 Container (bottle, box, barrel, cylinder, etc.)</p> <p><input type="checkbox"/> 11 Curb</p> <p><input type="checkbox"/> 12 Doors (automatic, manual, revolving)</p> <p><input type="checkbox"/> 13 Drugs or medicine</p> <p><input type="checkbox"/> 14 Dust</p> <p><input type="checkbox"/> 15 Electrical apparatus</p> <p><input type="checkbox"/> 16 Elevator, escalator</p> <p><input type="checkbox"/> 17 Explosives</p> <p><input type="checkbox"/> 18 Eyewear</p> <p><input type="checkbox"/> 19 Fan</p> <p><input type="checkbox"/> 20 Fire, flame, smoke</p> <p><input type="checkbox"/> 21 Floor</p> <p><input type="checkbox"/> 22 Food products</p> <p><input type="checkbox"/> 23 Fumes</p> <p><input type="checkbox"/> 24 Furniture, fixtures</p> <p><input type="checkbox"/> 25 Gas</p> <p><input type="checkbox"/> 26 Glass items</p> <p><input type="checkbox"/> 27 Gun</p> <p><input type="checkbox"/> 28 Ground (earth)</p> <p><input type="checkbox"/> 29 Hand tool</p> <p><input type="checkbox"/> 30 Heating equipment</p> <p><input type="checkbox"/> 31 Hoisting equipment</p> <p><input type="checkbox"/> 32 Icy condition</p> <p><input type="checkbox"/> 33 Infectious or parasitic agent</p> <p><input type="checkbox"/> 34 Inmate</p> <p><input type="checkbox"/> 35 Insect</p> <p><input type="checkbox"/> 36 Kitchen equipment</p> <p><input type="checkbox"/> 37 Knife</p> <p><input type="checkbox"/> 38 Lighting fixture and equipment</p> <p><input type="checkbox"/> 39 Ladder, scaffold</p> <p><input type="checkbox"/> 40 Locker</p> <p><input type="checkbox"/> 41 Machine</p> <p><input type="checkbox"/> 42 Material handling equipment</p> <p><input type="checkbox"/> 43 Metal</p> <p><input type="checkbox"/> 44 Mineral items (asphalt, clay, gravel, etc.)</p> <p><input type="checkbox"/> 45 Motor vehicle</p> <p><input type="checkbox"/> 46 Needle</p> <p><input type="checkbox"/> 47 Office equipment (chair, desk, cabinet, etc.)</p> <p><input type="checkbox"/> 48 Paint</p> <p><input type="checkbox"/> 49 Particle</p> <p><input type="checkbox"/> 50 Pavement</p> <p><input type="checkbox"/> 51 Person (other than client, inmate, employee)</p> <p><input type="checkbox"/> 52 Pipe</p> <p><input type="checkbox"/> 53 Platform, dock, ramp</p> <p><input type="checkbox"/> 54 Pole</p> <p><input type="checkbox"/> 55 Power tool or machinery (lathe, saw, etc.)</p> <p><input type="checkbox"/> 56 Radiation equipment (laser, microwave, x-ray, UV, etc.)</p> <p><input type="checkbox"/> 57 Receptacle</p> <p><input type="checkbox"/> 58 Smoke</p> <p><input type="checkbox"/> 59 Stair, step</p> <p><input type="checkbox"/> 60 Sun</p> <p><input type="checkbox"/> 61 Trench/Ditch</p> <p><input type="checkbox"/> 62 Vegetation</p> <p><input type="checkbox"/> 63 Weather</p> <p><input type="checkbox"/> 64 Wood</p> <p><input type="checkbox"/> 65 Other (specify) _____</p>
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I. Statement of the Injured person,if obtainable

(To be completed in injured person’s handwriting. Please use ink pen, no pencil.)

What happened?

What is the extent of your injurie(s), if any?

Your address and phone number:

Signature of injured person

Date

Description of incident by UNT Health Science Center personnel making this report. (Please report facts, do not make conclusions.)

Name of person making this report (print)

Signature of person making this report

Phone

Safety Office

Signature

Date

Quality Assurance

Signature

Date