

Blinn College Incident Report

*Form to be completed within 48 hours of the incident

Today's Date:		Time: am / pm	
Person Involved Information			
Name: (last)		(first)	(mi)
<input type="checkbox"/> Student <input type="checkbox"/> Faculty <input type="checkbox"/> Staff <input type="checkbox"/> Visitor <input type="checkbox"/> Contractor		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Birth date: Age:
Address:		City:	State: Zip:
Phone: ()	Email:	Blinn ID:	
Campus: <input type="checkbox"/> Brenham <input type="checkbox"/> Bryan <input type="checkbox"/> Schulenburg <input type="checkbox"/> Sealy		Department:	Work. Ext.
Job Title:		Supervisor:	Supv. Ext.
Incident Information			
Incident Date:		Incident Time: <input type="checkbox"/> am / <input type="checkbox"/> pm	
Campus: <input type="checkbox"/> Brenham <input type="checkbox"/> Bryan <input type="checkbox"/> Schulenburg <input type="checkbox"/> Sealy		Building:	Area/Room:
Incident Type		Nature of Event	
<input type="checkbox"/> Fall (same level)	<input type="checkbox"/> Electrical	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Hypothermia
<input type="checkbox"/> Fall (elevated)	<input type="checkbox"/> Violence	<input type="checkbox"/> Amputation	<input type="checkbox"/> Hearing
<input type="checkbox"/> Struck by	<input type="checkbox"/> Environmental	<input type="checkbox"/> Burn	<input type="checkbox"/> Vision
<input type="checkbox"/> Struck against	<input type="checkbox"/> Machinery	<input type="checkbox"/> Frost bite	<input type="checkbox"/> Laceration
<input type="checkbox"/> Motor vehicle	<input type="checkbox"/> Tool	<input type="checkbox"/> Heat cramps	<input type="checkbox"/> Fracture
<input type="checkbox"/> Caught between	<input type="checkbox"/> Medical	<input type="checkbox"/> Heat exhaust	<input type="checkbox"/> Electrical shock
<input type="checkbox"/> Chemical	<input type="checkbox"/> Trauma	<input type="checkbox"/> Heat stroke	<input type="checkbox"/> Sprain
<input type="checkbox"/> Fire	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	
Involved Body Part			
Upper Body		Trunk	
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Front <input type="checkbox"/> Back		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Front <input type="checkbox"/> Back	
<input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Neck		<input type="checkbox"/> Chest <input type="checkbox"/> Upper <input type="checkbox"/> Lower	
<input type="checkbox"/> Arm <input type="checkbox"/> Upper <input type="checkbox"/> Lower		<input type="checkbox"/> Hip <input type="checkbox"/> Leg <input type="checkbox"/> Upper <input type="checkbox"/> Lower	
<input type="checkbox"/> Hand <input type="checkbox"/> Finger(s):		<input type="checkbox"/> Abdomen <input type="checkbox"/> Upper <input type="checkbox"/> Lower	
		<input type="checkbox"/> Back Upper Lower	
Medical Actions			
<input type="checkbox"/> First Aid (only)	Transported to: <input type="checkbox"/> Clinic <input type="checkbox"/> Hospital	By: <input type="checkbox"/> EMS <input type="checkbox"/> Car	Admitted: <input type="checkbox"/> Yes <input type="checkbox"/> No
Back to work: <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Restrictions: <input type="checkbox"/> No <input type="checkbox"/> Yes (list) :	Fatality: <input type="checkbox"/> Yes <input type="checkbox"/> No	
After Action Review			
What happened:			
What was supposed to happen:			
Immediate actions:			
Corrective actions:			
Submitter Information			
Name:		Phone Ext.	Email:
Signature:			

*Completed form to be submitted to the Emergency Management Coordinator and HR compensation.