

SKIDMORE

C O L L E G E

STUDENT / VISITOR / GUEST (NON-EMPLOYEE) INJURY/ACCIDENT REPORT

Personal Information:

Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Permanent Address: _____ Phone: (____) _____

City: _____ State: _____ Zip: _____

Status (check one): ☐ Student ☐ Alumni - If Student/Alumni, Class Year: _____

☐ Guest/Visitor ☐ Volunteer ☐ Summer/Special Program Participant ☐ Other: _____

Detail of Injury/Accident:

Date of Injury/Accident: _____ Time of Injury/Accident: _____ ☐ am ☐ pm

Location where Injury/Accident Occurred: _____

Activity Engaged in at Time of Injury/Accident: _____

Body Part Injured: ☐ Right ☐ Left

<input type="checkbox"/> Ankle	<input type="checkbox"/> Ear	<input type="checkbox"/> Forearm	<input type="checkbox"/> Heel	<input type="checkbox"/> Mouth
<input type="checkbox"/> Shin	<input type="checkbox"/> Toe	<input type="checkbox"/> Bicep	<input type="checkbox"/> Elbow	<input type="checkbox"/> Forehead
<input type="checkbox"/> Hip	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Triceps	<input type="checkbox"/> Buttocks
<input type="checkbox"/> Eye	<input type="checkbox"/> Groin	<input type="checkbox"/> Jaw	<input type="checkbox"/> Nose	<input type="checkbox"/> Sternum
<input type="checkbox"/> Upper Back	<input type="checkbox"/> Calf	<input type="checkbox"/> Eyebrow	<input type="checkbox"/> Hamstring	<input type="checkbox"/> Knee
<input type="checkbox"/> Quadriceps	<input type="checkbox"/> Stomach	<input type="checkbox"/> Wrist	<input type="checkbox"/> Chest	<input type="checkbox"/> Finger
<input type="checkbox"/> Hand	<input type="checkbox"/> Lip	<input type="checkbox"/> Palm	<input type="checkbox"/> Tailbone	<input type="checkbox"/> Throat
<input type="checkbox"/> Collar Bone	<input type="checkbox"/> Foot	<input type="checkbox"/> Head	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Ribs
				<input type="checkbox"/> Other: _____

Medical Care Provided? ☐ Yes ☐ No If Yes, Facility Location/Treating Physician: _____

Campus Safety Notified? ☐ Yes ☐ No Ambulance Called? ☐ Yes ☐ No

Specific Description of how the Injury Occurred: _____

Witness Information:

Witness #1 Name _____ Witness #2 Name _____

Phone or Contact Info: _____ Phone or Contact Info: _____

Signature:

I have verified that this information is complete and accurate.

Injured Person's Signature (whenever possible)

Date

Signature of Person Completing Form

Date

If there are any questions, please call the Business Services Office at (518) 580-5812

Send Original to:

Office of Business Services, Skidmore College, 815 North Broadway, Saratoga Springs, NY 12866, Fax: 518-580-5818