COLUMBIA UNIVERSITY DEPARTMENT OF CHEMISTRY
Department Incident/Accident/Spill Form

I. INCIDENT DATA

Name of employee with direct knowledge of the incident_____
Date and Time of Incident_____
Location (Building, Room) _____
Were there any injuries? yes_____ no_____ (If "yes" describe in Section II)
Describe the incident and events leading to any injuries_____
_____
_____
Names of Witnesses (if any)_____

II. INJURY DATA, IF APPLICABLE (TO BE FILLED OUT BY INJURED EMPLOYEE)

What time did you start working? _____
What were you doing when injured?_____
Was the injury caused by a sharp object (needle, scalpel, razor)? If so, specify device type and brand _____
Describe object or substance (e.g., chemical, blood) that directly injured you _____
_____
Describe the injury/illness (indicate type of injury: specify left or right, e.g., "upper right leg")
_____
To whom did you report the accident? _____
Date reported _____Time_____

III. SUPERVISOR'S STATEMENT

How might this type of incident be prevented in the future? _____
_____
_____
Was employee paid for a full day?_____ Did employee lose work time? _____
Employee's first day away from work _____
Expected (or actual) date of return_____
Was employee paid for lost time? _____
If so, how many days at 100%?_____ at 80%? _____ Other? _____
Did the employee receive medical attention?_____ Date_____
Name and address of doctor or hospital where first treated _____

IV CONTACT INFORMATION

Primary contact person for this incident _____Title _____
Telephone number_____
Fax number _____

I CERTIFY THAT THE DATA PROVIDED ABOVE ARE TRUE:
Employee's Signature _____ Date _____ Time _____
Supervisor's Signature _____ Date _____ Time _____
Supervisor's comments (if any) _____
_____