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)__________________________________________________