



**INCIDENT/ACCIDENT REPORT
(Other than Motor Vehicle or
Employee/Volunteer Injury)**

STD. 268 (CP REV. 10-09)

**Injury/Illness, Damage
on Campus
or at a
University Activity**

*This report should be completed
and distributed within 48 hours of
the incident. Attach any photos,
maps, additional pages or diagrams.*

CONFIDENTIAL--ATTORNEY/CLIENT PRIVILEGED DOCUMENT

This is a CONFIDENTIAL report to provide information for use by legal counsel in the event a claim is filed against the State or its employees. Under no circumstances should information be given to anyone except authorized state officials.

INCIDENT DATE	POLICE NOTIFIED <input type="checkbox"/> YES <input type="checkbox"/> NO	LOCATION (Describe specific location on reverse)	TIME
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INJURED PARTY/PERSON INFORMATION

INJURED PARTY'S NAME (Last, First, M.I.)	BIRTH DATE	DRIVER'S LICENSE NUMBER
INJURED PARTY'S MAILING ADDRESS (Street, City, State, Zip)	HOME TELEPHONE NUMBER ()	WORK TELEPHONE NUMBER ()

NATURE AND EXTENT OF APPARENT / CLAIMED INJURY (Describe incident in detail on reverse.)

PHOTOGRAPHS TAKEN <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, BY WHOM _____	FIRST AID GIVEN <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, BY WHOM _____
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PROPERTY DAMAGE/LOSS INFORMATION

PROPERTY OWNER'S NAME (Last, First, M.I.)	HOME TELEPHONE NUMBER ()	WORK TELEPHONE NUMBER ()
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PROPERTY OWNER'S MAILING ADDRESS (Street, City, State, Zip)

NATURE AND EXTENT OF DAMAGE / LOSS (Describe in detail on reverse of this page)

WITNESS INFORMATION

NAME (Last, First, M.I.)	ADDRESS (Street, City, State, Zip)	TELEPHONE NUMBER
1.	WORK _____	() _____
DRIVER'S LICENSE NUMBER:	HOME	()
2.	WORK _____	() _____
DRIVER'S LICENSE NUMBER:	HOME	()

REPORTING CAMPUS OFFICE, DEPARTMENT, PROGRAM NAME:

REPORTING EMPLOYEE'S NAME AND TITLE (Print or Type)	TELEPHONE NUMBER ()
REPORTING EMPLOYEE'S SIGNATURE	POSITION/TITLE
REPORTING EMPLOYEE'S SUPERVISOR'S NAME AND TITLE (Print or Type)	TELEPHONE NUMBER ()

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STD. 268 (REV. 8-94)

USE ADDITIONAL SHEETS AS NECESSARY

DESCRIBE SPECIFIC LOCATION OF THE INCIDENT (IF NEEDED ATTACH MAPS AND MARK LOCATION)

SPECIFIC DETAILS TO INCLUDE: NATURE OF NJURED PERSON WITH THE UNIVERSITY (IF AN EMPLOYEE OR REGISTERED VOLUNTEER STOP AND CONTACT 805-756-5427)

WAS THIS A CLASS, FIELD TRIP, FREETIME, LAB, LECTURE PLEASE DESCRIBE GIVE ALL DETAILS AS TO TITLE OF CLASS, FIELD TRIP, LAB AND THE SPECIFIC TIME, etc.

ADDITIONAL TOOLS, MATERIALS (SOLID, LIQUID, GAS, ETC), OR EQUIPMENT IN USE DURING THIS TIME? PLEASE GIVE DETAILS

WAS THERE SAFETY EQUIPMENT IN USE?

YES NO If "yes" please specify

WAS SAFETY TRAINING PROVIDED PRIOR TO INCIDENT

YES NO If "yes" please describe.

DESCRIBE ANY SAFETY TRAINING THAT WAS GIVEN BEFORE INCIDENT

DESCRIBE ANY CONDITIONS (INSIDE OR OUTSIDE) THAT MAY HAVE CONTRIBUTED TO THE INJURY

WAS THERE A RELEASE AGREEMENT SIGNED BEFORE THE ACTIVITY?

YES NO If "yes" please send the release with this report to Risk Management Office – Building 1 Room 128

UNIVERSITY EMPLOYEES, (FACULTY, STAFF, STUDENT ASSISTANT, UNIVERSITY VOLUNTEER,) FOUNDATION EMPLOYEE, AND/OR ASI EMPLOYEES ARE TO REPORT INJURIES TO THEIR SUPERVISOR, REQUEST AND COMPLETE WORKERS COMPENSATION REPORT OF INJURY FORM FROM THEIR PERSPECTIVE EMPLOYERS, AND RETURN IT TO THE APPROPRIATE HUMAN RESOURCE DEPARTMENT.