

ST. CLOUD STATE UNIVERSITY  
STATE OF MINNESOTA  
INCIDENT REPORT

To be completed by employee who witnesses or is told about an incident.  
Injured party should not complete or sign this form.  
Submit immediately to Administrative Services, Room 205. Retain 2nd Copy.

Employee injuries (including student employees)  
should be reported to Personnel, ext. 3203

DATE OF INCIDENT: \_\_\_\_\_ TIME: \_\_\_\_\_ a.m. WEATHER \_\_\_\_\_ (if applicable)  
p.m. CONDITIONS: \_\_\_\_\_

LOCATION OF INCIDENT: \_\_\_\_\_ DESCRIPTION OF INCIDENT (How, Why):

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PERSON INJURED: NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

DESCRIPTION OF INJURY TO PERSON: \_\_\_\_\_

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MEDICAL TREATMENT (Person/Place Administering Aid): \_\_\_\_\_

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WITNESSES (Name, Addresses and Telephone): \_\_\_\_\_

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EXTENT OF DAMAGE TO PROPERTY: \_\_\_\_\_

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PRINTED NAME OF PERSON COMPLETING FORM: \_\_\_\_\_

SIGNATURE OF PERSON COMPLETING FORM: \_\_\_\_\_

(I acknowledge that I have received a copy of this report. Keep 2nd copy.)

DEPARTMENT \_\_\_\_\_ PHONE: \_\_\_\_\_ DATE: \_\_\_\_\_

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Persons who wish to file a claim against the University should call Administrative Affairs, Extension 2286, within thirty (30) days of the date of the incident.