

First Report of Accident/Incident Form
 SMU Office of Risk Management
 214.768.2807 · fax: 214.768.4138



Section A: Accident/Incident Details (<i>Sections A and E must be completed</i>)	
Reported by: _____ Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Primary Phone: _____ Secondary Phone: _____	Information About Other Party Involved Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Primary Phone: _____ Secondary Phone: _____
Persons Involved <input type="checkbox"/> Faculty <input type="checkbox"/> Staff <input type="checkbox"/> Student <input type="checkbox"/> Visitor <input type="checkbox"/> Other Department: _____ Supervisor: _____ Supervisor's Phone: _____	Persons Involved <input type="checkbox"/> Student <input type="checkbox"/> Employee <input type="checkbox"/> Visitor <input type="checkbox"/> Other Party was on campus because: _____ _____ _____
Date and Time of Accident/Incident _____ / _____ / _____ <small>MM DD YYYY</small>	Location of Accident/Incident <input type="checkbox"/> SMU: Main Campus <input type="checkbox"/> SMU in Plano <input type="checkbox"/> SMU: East Campus <input type="checkbox"/> SMU in Taos Building: _____ Rm #: _____ <input type="checkbox"/> Campus Grounds Location: _____ <input type="checkbox"/> Off Campus City: _____ State: _____ Street Location: _____ Purpose of Trip: _____ _____
Date and Time Reported _____ / _____ / _____ <small>MM DD YYYY</small>	
Accident/Incident Type (<i>please check all that apply</i>) <input type="checkbox"/> Personal Injury / Illness (complete section B) <input type="checkbox"/> Work Related (complete section B) <input type="checkbox"/> Vehicle Accident (complete section C) <input type="checkbox"/> Property Damage (complete section D) <input type="checkbox"/> Other (explain in section E)	
Injury Information Was anyone injured? <input type="checkbox"/> Yes <input type="checkbox"/> No Were the following contacted? (<i>please check all that apply</i>) Supervisor <input type="checkbox"/> Yes <input type="checkbox"/> No SMU Police <input type="checkbox"/> Yes <input type="checkbox"/> No Municipal Police <input type="checkbox"/> Yes <input type="checkbox"/> No Emergency Medical Staff <input type="checkbox"/> Yes <input type="checkbox"/> No Parent <input type="checkbox"/> Yes <input type="checkbox"/> No	Witness Information Where there witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please provide name(s) and contact information: Witness 1 Name: _____ Contact Information: _____ Witness 2 Name: _____ Contact Information: _____ Witness 3 Name: _____ Contact Information: _____
Section B: Personal Injury (<i>If the injury is work related, please refer to <u>Workers' Compensation Manual</u> for more information</i>)	
Injured Party's Name: _____ DOB: _____ / _____ / _____ SSN/ID #: _____ <small>MM DD YYYY</small> Cause of Injury: _____ Multiple Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No Part(s) of Body Injury: _____	

