

MICHIGAN STATE UNIVERSITY

INJURY/PROPERTY DAMAGE REPORT

Office of Risk Management & Insurance
113 Olds Hall
East Lansing, MI 48824-1047
Phone (517) 355-5022
Fax (517) 432-3854
E-mail: risk.management@ctrl.msu.edu

Please PRINT or TYPE

THIS FORM IS A CONFIDENTIAL – INTERNAL DOCUMENT TO BE COMPLETED BY MSU EMPLOYEE

TIME & PLACE	Date/Time of Incident	Location: Street, City, MSU Bldg. Rm #		
PREMISES CONDITION	Type of Premises		Conditions	
	<input type="checkbox"/> Construction Site	<input type="checkbox"/> Parking Lot	<input type="checkbox"/> Dry	<input type="checkbox"/> Uneven Surface
	<input type="checkbox"/> Hallway	<input type="checkbox"/> Sidewalk	<input type="checkbox"/> Icy	<input type="checkbox"/> Other:
	<input type="checkbox"/> Lobby/Entrance	<input type="checkbox"/> Stairway	<input type="checkbox"/> Snowy	
	<input type="checkbox"/> Office	<input type="checkbox"/> Street	<input type="checkbox"/> Wet	
	<input type="checkbox"/> Other:			
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED:			
INJURED PERSON	NAME	AGE	PHONE #	
	ADDRESS			
DESCRIPTION OF INJURY	INJURY - Describe the type, severity, and body part involved			
	Was Medical Treatment Given? Yes <input type="checkbox"/> No <input type="checkbox"/>		Will seek treatment later <input type="checkbox"/>	
	Name of Medical Facility/Doctor		<input type="checkbox"/> Transported by Ambulance <input type="checkbox"/> Transported by Other:	
PROPERTY DAMAGE	OWNER'S NAME	ADDRESS	PHONE #	
	Describe the property and the damage			Estimated Repair/Replacement Cost
WITNESSES GIVE THE FULL NAME & ADDRESS OF EACH WITNESS	NAME	ADDRESS	PHONE#	

NAME/TITLE OF MSU EMPLOYEE COMPLETING THIS REPORT: _____ PHONE: _____ E-MAIL: _____

MSU DEPARTMENT: _____ DATE : _____

NAME/TITLE OF MSU EMPLOYEE'S SUPERVISOR: _____ PHONE: _____ E-MAIL: _____

SUPERVISOR'S SIGNATURE: _____