# First Report of Accident/Incident Form

Within 24 hours of accident/incident, return completed form to:
Office of Risk Management
PO Box 231
Main: 214-768-2083 / Fax Number: 214-768-4138 or Email: riskmanagement@smu.edu

## SECTION A: ACCIDENT/INCIDENT DETAILS

*Check all that apply:*

- [ ] Personal Injury/Illness
- [ ] Vehicle Accident
- [ ] Property Damage

### PERSON INVOLVED

- [ ] Faculty
- [ ] Staff
- [ ] Student
- [ ] Visitor

Name: __________________________
Primary Phone: __________________

Home Address:
Street Address __________________
City __________________ State ________ Zip Code __________

Department (if applicable): __________
Supervisor (if applicable): ___________________________
Name: __________ Phone: __________

Purpose of visit to campus: __________________________

### INCIDENT REPORTED BY

- [ ] Faculty
- [ ] Staff
- [ ] Student
- [ ] Visitor

Name: __________________________
Primary Phone: __________________

Address:
Street Address __________________
City __________________ State ________ Zip Code __________

### DETAILS

**Location:**
- [ ] Main Campus
- [ ] SMU-East Campus
- [ ] SMU Plano
- [ ] SMU Taos
- [ ] Off Campus

Building/Location: __________________________

**Accident/Incident:** Date: _________ Time: _______ **Accident Reported:** Date: _________ Time: _______

**Weather Conditions:** __________________________

**Who was contacted?** (Check all that Apply)

- [ ] Supervisor
- [ ] SMU Police
- [ ] Municipal Police
- [ ] Emergency Medical
- [ ] Parent

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**SECTION B: PERSONAL INJURY SECTION**

| Cause of Injury: ___________________________ | Part of Body Injured: ___________________________ |
| Witness Name(s): ___________________________ | Contact Info: ___________________________________ |
| Witness Name(s): ___________________________ | Contact Info: ___________________________________ |

What happened to the injured party?  
☐ First Aid Administered  ☐ Refused Treatment/Transport  ☐ Left With Friend  ☐ Transported to Hospital  
☐ Returned to Work  ☐ Went Home  ☐ Went to Physician  ☐ Unknown

Was injury a result of a motor vehicle accident?  ☐ YES  ☐ NO  
(If yes, complete Section C)

Was SMU property damaged?  ☐ YES  ☐ NO  
(If yes, complete Section D)

**SECTION C: AUTO ACCIDENT**

| Vehicle 1: | Vehicle 2 |
| SMU Owned: ☐ YES  ☐ NO | SMU Owned: ☐ YES  ☐ NO |
| Driver’s Name: ___________________________ | Driver’s Name: ___________________________ |
| Driver’s License Number: ___________________________ | Driver’s License Number: ___________________________ |
| State: _________  Driver DOB: __________ | State: _________  Driver DOB: __________ |

Description of Vehicle:

Make: __________  Model: __________  
Year: __________  Color: __________  
License Plate Number: __________  
Insurance: ___________________________  
Policy Number: ___________________________

Was SMU property damaged?  ☐ YES  ☐ NO  
(If yes, complete Section D)

Was anyone injured?  ☐ YES  ☐ NO  
(If yes, complete Section B)

**SECTION D: PROPERTY DAMAGE**
<table>
<thead>
<tr>
<th>Cause of Damage(s):</th>
<th>______________________________</th>
<th>Was building occupied? □ YES □ NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witness Name(s):</td>
<td>______________________________</td>
<td>Contact Info:</td>
</tr>
<tr>
<td>Witness Name(s):</td>
<td>______________________________</td>
<td>Contact Info:</td>
</tr>
<tr>
<td>Was anyone injured?</td>
<td>□ YES □ NO (If yes, complete Section B)</td>
<td></td>
</tr>
<tr>
<td>Was a motor vehicle involved?</td>
<td>□ YES □ NO (If yes, complete Section C)</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION E: DETAILED DESCRIPTION**

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

I hereby certify that the above information is true and correct to my understanding of this incident.

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Signature</th>
<th>Date and Time</th>
</tr>
</thead>
</table>

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