

## Facility User Injury Reporting Instruction

**PLEASE PRINT ALL INFORMATION LEGIBLY - DO NOT use this form for EMPLOYEE injuries.**

To Be Used By Staff For Reporting Basic injury Information; if the patron is transported by ambulance, or a fatality occurs notify Risk Management immediately 459-1344, after hours 590-4934.

This report must be filled out immediately on the day of the injury and submitted to Risk Management through e-mail to [ReportClaims@fnsb.gov](mailto:ReportClaims@fnsb.gov) or in-house mail or fax to 459-1187.

1. INJURED PARTY INFORMATION	THIS INFORMATION HELPS...
Facility where incident occurred Name Parent or Guardian if Minor Contact Number Gender and Age Address, City, State, and Zip Code	Risk Management to identify specific incidents should care become necessary for the injured party
2. DATE/TIME OF INJURY/LOCATION OF INJURY	THIS INFORMATION IS IMPORTANT WHEN.....
Enter the date and time when the injury occurred. Location in/at the facility where the incident occurred. Be as Specific as possible – Include room numbers, equipment involved, etc.	Risk Management investigates injuries and this information narrows down the specifics of when and where the injury occurred.
3. INJURY DETAILS	THIS INFO IS IMPORTANT BECAUSE IT PROVIDES....
Be as specific as possible. Be sure to provide 1. Cause of the Injury - answer the question "what were you doing when the accident occurred?" 2. Nature of the injury - answers the question "what is the injury?" a. What part(s) of the body were injured – Be sure to identify if it is left side, right side, or N/A (mark all that apply) b. Nature of injury (mark all that apply) 3. Objects/Substances/Activities Involved – answer the question "what was happening and what was involved at the moment the injury occurred?" a. Lighting – If applicable b. Surface Conditions – If applicable c. Type of equipment being used – if applicable	<p><b>Cause of the Injury</b> - Give specific details about the activities involved. Examples include "jumping off high dive", "walking into building slipped and fell", or "skating during free skate", etc.</p> <p><b>Nature of the Injury</b> - This should include the part of body affected, on what side of the body the injury occurred (if applicable) and how the body part was affected. For example, "fractured left wrist", "contusion to forehead and neck strain", etc.</p> <p><b>Objects/Substances/Activities Involved</b> - Identify the <i>immediate</i> cause of the injury and anything involved. If lighting or surface conditions played a factor in the injury/incident identify why it did so. For example, "fell while skating and struck head on ice", "struck high dive board when diving", "snow/ice covered the curb", etc.</p>
4. ASSISTANCE PROVIDED	THIS INFO IS IMPORTANT BECAUSE.....
What assistance was provided? 1. First Aid a. Who administered first aid? b. What type of first aid was given? 2. Notified family 3. Referred to Dr. 4. Called 911 5. None/Declined 6. If the patron is transported by ambulance, or a fatality occurs notify Risk Management immediately 459-1344, after hours 590-4934.	It provides Risk Management with details of any assistance provided to the injured party should further care become necessary.
5. WITNESS(ES)	THIS INFO IS IMPORTANT BECAUSE.....
Provide the Name and contact number for any witnesses.	Provides us with individual(s) that have knowledge of the incident.
6. REPORTED BY SIGNATURE	THIS INFO IS IMPORTANT BECAUSE.....
Printed name and signature of the individual completing the injury report the date the form was completed.	If we need further information concerning this incident this is who we will contact.
7. SUBMIT THE REPORT TO RISK MANAGEMENT	IMPORTANT BECAUSE
E-mail ( <a href="mailto:ReportClaims@fnsb.gov">ReportClaims@fnsb.gov</a> ) OR Fax (907-459-1187) OR send through in house mail.	Timely notification allows for follow up and any corrective actions that might need to be implemented.

# Facility User Injury Report

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If the patron is transported by ambulance, or a fatality occurs notify Risk Management immediately 459-1344, after hours 590-4934.

<b>Facility</b>				<b>Bus/Van Tran Unit Number (if applicable):</b>							
Injured Party Information	Name of Person Injured		Parent or Guardian if Minor		Contact Number		Gender	Age			
							M	F			
	Address			City		State	Zip Code				
Time / Location	Date	Time		am	Location in/at facility (be specific, include room numbers, etc.)						
				pm							
Full description of Incident Including any contributing factors (be specific)											
Injury Details	<b>Part(s) of Body Injured</b>										
	<b>Position of Body Part(s) Injured</b>	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Finger(s)	<input type="checkbox"/> Knee	<input type="checkbox"/> Nose	<input type="checkbox"/> Toes	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Lower Arm	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Upper Arm
	<input type="checkbox"/> Buttocks	<input type="checkbox"/> Great Toe	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Scalp	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Chest	<input type="checkbox"/> Groin	<input type="checkbox"/> Lower Leg	<input type="checkbox"/> Shoulder(s)	<input type="checkbox"/> Upper Leg	
<input type="checkbox"/> Left	<input type="checkbox"/> Ear(s)	<input type="checkbox"/> Hand(s)	<input type="checkbox"/> Mid Back	<input type="checkbox"/> Skull	<input type="checkbox"/> Whole Body	<input type="checkbox"/> Right	<input type="checkbox"/> Elbow	<input type="checkbox"/> Mouth	<input type="checkbox"/> Teeth	<input type="checkbox"/> Wrist(s)	
<input type="checkbox"/> N/A	<input type="checkbox"/> Eye(s)	<input type="checkbox"/> Hip	<input type="checkbox"/> Neck	<input type="checkbox"/> Thumb	<input type="checkbox"/> Other						
<b>Nature of Injury (mark all that apply)</b>											
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Concussion	<input type="checkbox"/> General Soreness	<input type="checkbox"/> Puncture								
<input type="checkbox"/> Allergic Reaction	<input type="checkbox"/> Contusion/Bruise	<input type="checkbox"/> Laceration / Cut	<input type="checkbox"/> Scratch								
<input type="checkbox"/> Animal/Insect Bite	<input type="checkbox"/> Dislocation	<input type="checkbox"/> No Physical Injury	<input type="checkbox"/> Sprain								
<input type="checkbox"/> Burn	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Nose Bleed	<input type="checkbox"/> Strain								
<input type="checkbox"/> Chipped/Broken Tooth	<input type="checkbox"/> Fracture	<input type="checkbox"/> Other:									
<b>Lighting (if applicable)</b>				<b>Surface Conditions (if applicable)</b>							
<input type="checkbox"/> Natural Daylight	<input type="checkbox"/> Defective	<input type="checkbox"/> Muddy	<input type="checkbox"/> Wet								
<input type="checkbox"/> Artificial Light	<input type="checkbox"/> Dry	<input type="checkbox"/> Rainy	<input type="checkbox"/> Other _____								
<input type="checkbox"/> Dark	<input type="checkbox"/> Gravel	<input type="checkbox"/> Snowy	<input type="checkbox"/> Other _____								
<input type="checkbox"/> Unlighted	<input type="checkbox"/> Icy	<input type="checkbox"/> Uneven									
Assistance Provided	What Assistance was given?										
	<input type="checkbox"/> First Aid	<input type="checkbox"/> Notified Family	<input type="checkbox"/> Referred to Dr.	<input type="checkbox"/> Called 911	<input type="checkbox"/> None/Declined						
	Who administered First Aid? _____										
Type of First Aid Given? _____											
<b>If the patron is transported by ambulance, or a fatality occurs notify Risk Management immediately 459-1344, after hours 590-4934.</b>											
Witnesses	Name / Contact Number			Name / Contact Number			Name / Contact Number				
Reported by	Printed Name			Signature/Digital Signature/Print			Date				