



The University of New Haven
300 Boston Post Road West Haven, Connecticut 06516
University Police X 7070 Student Health Services X 7079
Student Laboratory Accident / Near Miss Report

Please complete and Return to Ron Quagliani within 24 Hours of incident.

Date: _____

Time: _____

Name: _____

Location: _____

Department: _____

Course: _____

Instructor: _____

Phone: _____

Description of Accident or Near Miss: Please describe how the accident happened. What was the student doing? List any specific acts by individuals or conditions that led to the accident. (include any tools, machinery or instruments involved)

Nature of Injury		
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Cut	<input type="checkbox"/> Scratch
<input type="checkbox"/> Amputation	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Shock
<input type="checkbox"/> Asphyxiation	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain
<input type="checkbox"/> Bite	<input type="checkbox"/> Laceration	<input type="checkbox"/> Splinter
<input type="checkbox"/> Bruise	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Strain
<input type="checkbox"/> Burn	<input type="checkbox"/> Puncture	
<input type="checkbox"/> Concussion	<input type="checkbox"/> Repetitive Stress	
<input type="checkbox"/> Other (Specify) _____		

Part of Body Injured		
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Face	<input type="checkbox"/> Leg
<input type="checkbox"/> Ankle	<input type="checkbox"/> Finger	<input type="checkbox"/> Mouth
<input type="checkbox"/> Back	<input type="checkbox"/> Foot	<input type="checkbox"/> Nose
<input type="checkbox"/> Chest	<input type="checkbox"/> Forearm	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Ear	<input type="checkbox"/> Hand	<input type="checkbox"/> Teeth
<input type="checkbox"/> Elbow	<input type="checkbox"/> Head	<input type="checkbox"/> Wrist
<input type="checkbox"/> Eye	<input type="checkbox"/> Knee	
<input type="checkbox"/> Other (Specify) _____		

Witnessed By (if any): _____

Witnessed By (if any): _____

Contact Number: _____

Contact Number: _____

Was first aid administered? Yes ☐ No ☐

Did student go to Health Services? Yes ☐ No ☐

If first aid was administered, please describe (i.e. ice pack, band aid, etc.): _____

Loss of consciousness? Yes ☐ No ☐

Was EMS called? Yes ☐ No ☐

Did student refuse EMS first aid or EMS? Yes ☐ No ☐

Was student transported and where? _____

Signature of student refusing first aid or EMS transport: _____

Were photographs taken of the area and/or equipment involved in the accident or near miss? Yes ☐ No ☐

If pictures were taken, where are they being kept? _____

Corrective Action: In your opinion, what are reasonable actions or steps that could be taken to eliminate or reduce the likelihood of a recurrence.
Attach separate page if necessary.

Name of person completing form: _____

Date: _____

For Laboratory Manager Use Only

Laboratory Manager Signature: _____

Date: _____

Were laboratory safety procedures being followed at the time of the student accident/near miss?: Yes ☐ No ☐

Comments: _____

Please complete and return within 24 hours to Ron Quagliani, Gate House Room 101 - rquagliani@newhaven.edu

