

WVU EMPLOYEE INJURY/INCIDENT REPORT (Case # _____)

Contact within 24 hrs. Environmental Health and Safety (EHS) 304-293-3792. You can call in the injury at (304) 293-HURT (for Med Mgmt) and report the high-lighted questions. **Supervisors** complete **both pages** and immediately fax or email to EHS (304) 293-7257/ Carol.Wells@mail.wvu.edu and Med Mgmt. (304) 293-2644/ Amanda.Biddle@mail.wvu.edu.

EH&S use only	Reclassified ___	<input type="checkbox"/> Privacy Case <input type="checkbox"/> Needlestick <input type="checkbox"/> Body Fluids <input type="checkbox"/> Animal Bite <input type="checkbox"/> Asbestos <input type="checkbox"/> Chemical Spill <input type="checkbox"/> Pharmaceutical/Biohazard WVU Occupational Medicine Health Care Evaluation Recommended Describe on pg. 2 reason for Evaluation	Serious Injury ___ (Notify within 24 hrs. for hospitalization) Fatality ___ (Notify within 8 hrs.) Near Miss ___ Exposure ___
OSHA Recordable ___ Yes ___ No			

SECTION ONE

1. Name of Injured: _____ **2. WVU ID No. (700 xx xxxx):** _____
 (Last, Suffix) (First) (Middle) [Click here to look up WVU ID](#)

3. Gender: ___ Female ___ Male **4. Date of Birth** ___/___/___ or Age ___ **5. Date of Incident** ___/___/___

6. Time of Incident: ___:___ AM ___:___ PM during work ___ entering work ___ leaving work ___ lunch/break

7. Campus: Main ___ Potomac ___ WVUIT ___ **8. Department** _____ **9. Job Title** _____

10. Employment Category: (Check one) ___ Faculty ___ Staff ___ Student Employee ___ Research Corp ___ Health Sciences

11. Status: ___ Fulltime ___ Part-time ___ Temporary ___

12. Length of Employment: ___ years **13. Time in occupation when incident occurred:** ___ years

14. Describe Exactly what happened, Include timeline of event and OBJECT or SUBSTANCE that caused harm: i.e. slipped on wet floor, exposure to cleaning chemicals, cut with carpet knife. (For informational purposes, please submit detailed information on the attached "Incident Description Statement Form").

15. Location of Incident include building and room number, state if outdoors : i.e. Engineering Sciences Bldg., Rm G38

16. Describe the INJURY or ILLNESS and Specific BODY PART(S) affected: i.e. cut on palm of left hand or sprained lower back) Exposure -EHS must receive a completed copy of the "Employee Injury/Incident Report" within 24 hours of the exposure.

SECTION TWO

17. Wearing Personal Protective Equipment? (please specify) _____

18. Was the employee seen by a physician? ___ Yes ___ No **19.** Name of Physician _____

20. Location of Treatment _____

21. Was employee in Emergency room? ___ Yes ___ No **22.** Was employee hospitalized overnight as a patient? ___ Yes ___ No

23. Type of Treatment received: (check type)
 ___ Set Fracture/broken bone ___ Treat Infection ___ Stitches/Sutures ___ Tetanus Shot ___ Surgery
 ___ ADA concerns ___ Prescription ___ Physical Therapy (more than once) ___ Remove foreign Object from eye
 ___ Hearing Loss ___ Other-explain on back of form **Needlestick or Body Fluids – please report to local emergency room immediately and follow up with Occupational Medicine at (304) 293-3693.**

See link to CDC guidelines for Sharps injury treatment at <http://www.cdc.gov/niosh/stopsticks/whattodo.html>

SECTION THREE

24. Does employee wish to file a Worker Compensation Claim? ___ Yes ___ No

25. Does this incident require EHS to investigate for alternative information and causal factors? ___ Yes ___ No

Employee's Signature _____ Print _____ Ph. Number _____ Date _____

Supervisor's Signature _____ Print _____ Ph. Number _____ Date _____

Reviewer's Signature _____ Print _____ Date _____

