WVU EMPLOYEE INJURY/INCIDENT REPORT- REPORT INCIDENT WITHIN 24 HOURS Case #:_____

Call 9-911 for: loss of consciousness, stroke, seizures, heart attack, electric shock, allergic reaction or bleeding and Call EHS @ 304-293-3792 to report.

For EH&S use only	Reclassified __	____ Privacy Case ____ Needlestick ____ Body Fluids ____ Animal Bite ____ Asbestos ____ Chemical Spill ____Pharmaceutical/Biohazard WVU Occupational Medicine Health Care Evaluation Recommended Describe on page 2 reason for Evaluation	Serious Injury (Notify within 24 hrs. for hospitalization) Fatality____(Notify within 8 hrs.) *Near Miss*_____*Exposure*_____

SECTION ONE:

1. Name of Injured:_____ **2. WVU ID No. (700 xx xxxx):** _____
(Last, Suffix) (First) (Middle) **700# REQUIRED for incident to be processed**

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: *An example would be: 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., Room G38*

16. Describe the INJURY or ILLNESS and Specific BODY PART(S) affected: *(An example would be: 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. Was the victim 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
____Prescription ____Physical Therapy (more than once) ____Remove foreign Object from eye
____Hearing Loss ____ Does this issue need reviewed for ADA Concerns ____Other-explain on back of form

____ ***Needlestick or Body Fluids – please report to local emergency room immediately (Ruby hospital after 4:30 p.m.***

and call Occupational Medicine at 304.293.3693 for follow up) See link to CDC guidelines for Sharps injury treatment at http://www.cdc.gov/niosh/stopsticks/whattodo.html

SECTION THREE:

24. Total lost work days after the day of incident _____ **25.** Total days of restricted activity _____

26. If employee has not returned to work check here____

27. Does employee wish to file a Worker Compensation Claim?____Yes____No

Employee's Signature_____Print_____Ph. Number_____Date_____

Supervisor/Reviewer Signature_____Print_____Ph. Number_____Date_____

Complete form and immediately email to: *WVUInjuryIncidentReport@mail.wvu.edu* *(preferred)* or fax to EHS (304) 293-7257, or mail Environmental Health and Safety Injury/Incident, PO Box 6551, Morgantown, WV 26506.

INCIDENT DESCRIPTION STATEMENT FORM

Supervisor, Injured Employee, and Witness complete a separate Statement Form

Please check appropriate box

☐ Supervisor ☐ Employee ☐ Observer

Name of Injured Employee: _____

Date of Injury: _____

Description of Incident: **Describe in detail exactly what happened, Include: task(s) and procedure(s) being performed, timeline of events, and OBJECT and/or SUBSTANCE that may have been involved.**

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Name (Printed): _____

Signature: _____ Date: _____