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 Name, First Name) (Middle) **WVU ID Number REQUIRED to process incident**

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 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.

Name (Printed): ____

Signature: ______________________________ Date: ____________________

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