

STUDENT or VISITOR ACCIDENT REPORT FORM
West Virginia University
Environmental Health and Safety

THE INJURED STUDENT OR VISITOR AND WVU DEPARTMENT REPRESENTATIVE SHOULD COMPLETE THIS FORM.

Name: _____ Status: (check one) Student or Visitor

Phone: _____

Date: _____ Time accident occurred: _____

Sex: Male or Female (check one) Age: _____

Building/Location and Room or area in which accident occurred: _____

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

Nature of Injury			Part of Body Injured		
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Cut	<input type="checkbox"/> Scratch	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Face	<input type="checkbox"/> Leg
<input type="checkbox"/> Amputation	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Shock	<input type="checkbox"/> Ankle	<input type="checkbox"/> Finger	<input type="checkbox"/> Mouth
<input type="checkbox"/> Asphyxiation	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain	<input type="checkbox"/> Back	<input type="checkbox"/> Foot	<input type="checkbox"/> Nose
<input type="checkbox"/> Bite	<input type="checkbox"/> Laceration	<input type="checkbox"/> Splinter	<input type="checkbox"/> Chest	<input type="checkbox"/> Forearm	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Bruise	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Strain	<input type="checkbox"/> Ear	<input type="checkbox"/> Hand	<input type="checkbox"/> Teeth
<input type="checkbox"/> Burn	<input type="checkbox"/> Puncture	<input type="checkbox"/> Fainted	<input type="checkbox"/> Elbow	<input type="checkbox"/> Head	<input type="checkbox"/> Wrist
<input type="checkbox"/> Concussion	<input type="checkbox"/> Repetitive Stress Injury		<input type="checkbox"/> Eye	<input type="checkbox"/> Knee	
Other specify) _____			Other (specify) _____		

Was first aid administered? Y or N

Did you receive medical treatment? Y or N

Treatment location: _____

Signed: _____
or Student WVU Department Representative

Signed: _____
Visitor

E-Mail Original to: WVUInjuryIncidentReport@mail.wvu.edu