WVU EMPLOYEE INJURY/INCIDENT REPORT **(Case #_____)**

Contact within 24 hours: Environmental Health and Safety (EHS) (304-293-3792). You can call in the injury @ 304.293.HURT (for Med Mgmt)) and report the high-lighted information. ***Supervisors*** complete **both pages** and immediately fax to EHS (304)293-7257 and Med Mgmt (304)293-2644

For EH&S use only OSHA Recordable ___ Yes ____ No__	Reclassified __	Privacy Case_ WVU Occupational Medicine Health Care Evaluation Recommended ___ Describe on page 2 reason for Evaluation	Serious Injury Fatality __ *Near Miss*___

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: *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)*

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 Other (explain)_____

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 _____ *Please complete Employee Return-To-Work Notice)*

27. Was Worker Compensation Filed? _____Yes _____No

Employee's Signature _____Print _____Ph. Number_____Date_____

Supervisor's Signature_____Print_____ Ph. Number_____Date_____

Reviewer's Signature _____Print_____ Date_____

(**EHS use only) Healthcare Needlestick injuries only: Sharps Injury: _____ Body Fluids Exposure ____**

***RETURN FORM: Environmental Health and Safety - PO Box 6551 Morgantown, WV 26506-6551 --Fax* (304) 293-7257**
Email Forms to the persons listed below:

Email: *Carol.Wells@mail.wvu.edu and Amanda.Biddle@mail.wvu.edu and Angela Lemmon alemmon@hsc.wvu.edu.*

INCIDENT DESCRIPTION STATEMENT FORM Supervisor,
Injured Employee, and Witness complete a Separate Form

Please check appropriate box
□ Supervisor □ Employee □ Witness

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: _____

Supervisors complete form and immediately fax to EHS (304) 293-7257 or mail Environmental
Health and Safety Injury/Illness Prevention Program, PO Box 6551, Morgantown, WV 26506

Email: *Carol.Wells@mail.wvu.edu and Amanda.Biddle@mail.wvu.edu and Angela Lemmon alemmon@hsc.wvu.edu.*