# ACCIDENT / INJURED PERSON REPORT

**For WVUP use only** **Case Number: _____** **WVUP ID: _____**

**Hearing Loss: _____** **Sharps Injury: _____** **Assignment #: _____**
**Privacy Case: _____** **Fatality: _____** **Date of Death: _____**
**OSHA Recordable: _____Yes _____No _____Reclassified**

**1. Name of Injured:** _____

**2. Gender:** ☐ male ☐ female **3. Age: _____** **4. Day/Date of Accident: _____**

**5. Time of Incident:** ☐ AM ☐ PM ☐ during work ☐ entering work ☐ leaving work ☐ lunch break

**6. Campus Department: _____** **7. Job Title: _____**

**8. Category:** ☐ Faculty ☐ Staff ☐ Student ☐ Visitor ☐ Child in Daycare

**9. Status:** ☐ Full-time ☐ Part-time ☐ Temporary

**10. Length of Employment: _____** years **11. Time in occupation when incident occurred: _____** years

**12. Describe Exactly what happened: Include OBJECT or SUBSTANCE that caused harm**: (e.g. slipped on wet floor, exposure to cleaning chemicals, cut with carpet knife… use the back of this sheet if necessary)

**13. Location of Incident:**

**14. Describe the INJURY or ILLNESS and BODY PART(S) affected:** (e.g. cut on palm of left hand; sprained back)

**15. Was injured person wearing Personal Protective Equipment:** (please specify)

**16. Was injured person seen by a physician:** ☐ yes ☐ no **17. Name of Physician:_____**

**18. Treatment Location:_____**

**19. Was injured person taken to Emergency Room:** ☐ yes ☐ no

**20. Was injured person hospitalized overnight as a patient:** ☐ yes ☐ no

**21. Type of Treatment received:** ☐ Tetanus Shot ☐ Stitches/Sutures ☐ Treat Infection
☐ Set of fracture/broken bone ☐ Surgery ☐ Prescription
☐ Remove foreign object from eye ☐ Physical Therapy(more than once)

**Other(explain): _____**

**22. Total days of work lost after the incident: _____** days **23. Total days of restricted activity: _____** days

**24. If employee has not returned from work check here:** ☐ **(**Please fill out Employee Return-To-Work Notice)

**25. Was Worker's Compensation filed:** ☐ yes ☐ no

**Injured Person Signature: _____** **Date: _____**

**Supervisor's Signature: _____** **Date: _____**

**Reviewer's Signature**: **_____** **Date: _____**

**RETURN COMPLETED FORM TO:** WVU Parkersburg Safety Officer
Attn: Injury/Illness Prevention Program
300 Campus Drive, Parkersburg, WV 26104