Accident/Incident Report

VIRGINIA TECH - OFFICE OF RISK MANAGEMENT (0310)
BLACKSBURG, VA. 24061
540-231-7439 FAX: 540-231-5064

Name of Responsible Office_________________________ Date of Report ______________

Name of Responsible Virginia Tech Representative

Address __________________________________________ State _____ Zip ________

Phone_________________________________________

Name of Injured Person(s) or Involved Person(s)________________________________Age _____ Sex _____

Address __________________________________________ State _____ Zip ________

Phone_________________________________________

Name of Injured Person(s) or Involved Person(s)________________________________Age _____ Sex _____

Address __________________________________________ State _____ Zip ________

Phone_________________________________________

Name of Parent or Guardian (if minor) _________________________________________Age _____ Sex _____

Address __________________________________________ State _____ Zip ________

Phone_________________________________________

Name/Addresses of Witnesses (Each Witness Should Attach a Signed Statement of What Happened):

1. ________________________________________________________________________________________

2. ________________________________________________________________________________________

3. ________________________________________________________________________________________

* 18 USC 707
Type of Incident:
- Behavioral
- Accident
- Illness
- Other

Date of Incident/Accident: Hour ________ (am or pm)  Day ________  Month ________  Year ________

Describe the Incident in Detail:
___________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Location of Incident and Diagram Showing Objects and Persons:
________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

What Activity Was the Injured Participating in at the Time of the Incident?
_____________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Describe any Equipment Involved in the Incident:
_____________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Describe Emergency Procedures Followed as a Result of this Incident:
_____________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

MEDICAL REPORT OF INCIDENT

Were the Parents or Guardian Notified?  ☐ Yes  ☐ No
How?_____________________________________________

By Whom?_____________ Title_____________ When__________________________
Response of Individual Notified______________________________________________
Where was Treatment Given?

☐ At Accident Site ☐ Doctor’s Office ☐ Hospital ☐ Rescue Squad

Describe Treatment Given:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Treatment Given by Whom? _____________________________ Date of Treatment ____________

Was Injured Retained Overnight in Hospital?

☐ Yes ☐ No

If Yes, Where __________________________________________

Name of Attending Physician: ____________________________

Prognosis of Injured at the Time of Report: ____________________________

_____________________________________________________________________________________
_____________________________________________________________________________________

Comments ____________________________________________________________________________

_____________________________________________________________________________________
_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Person Completing Report __________________________ Signature ____________________________

Position __________________ Phone __________________ Fax _______________________

THIS ACCIDENT/INCIDENT REPORT IS NOT REQUIRED FOR INCIDENTS SUCH AS SCRAPES, BRUISES, SPRAINS, ETC. THIS INCIDENT REPORT IS REQUIRED FOR SERIOUS ILLNESSES, SIGNIFICANT BEHAVIORAL PROBLEMS OR ACCIDENTS INVOLVING INJURIES LIKE FRACTURED BONES, CHIPPED OR BROKEN TEETH, EXTENSIVE LACERATIONS INVOLVING SUTURES, FALLS INVOLVING UNCONCIOUSNESS, DISLOCATIONS, INCIDENTS INVOLVING WATER WHICH REQUIRE RESUSCITATION, OR ANY INJURY REQUIRING HOSPITAL STAY.

THIS ACCIDENT/INCIDENT REPORT IS ALWAYS REQUIRED WHEN THE PROCEDURES OUTLINED ON THE EMERGENCY RESPONSE CARD AND CARRIED BY ALL COOPERATIVE EXTENSION REPRESENTATIVES ARE INITIATED. ONCE COMPLETED THE FORM SHOULD BE FAXED TO 540-231-5064 AND MAILED THE VIRGINIA TECH OFFICE OF RISK MANAGEMENT.