

Contact within 24 hours: Environmental Health and Safety (EHS) (304-293-3792) and Medical Management (304.293.HURT) that an injury has occurred. **Supervisors** complete **both pages** and immediately fax to EHS (304) 293-57257

For EH&S use only	OSHA Recordable <input type="checkbox"/> Yes <input type="checkbox"/> No	Reclassified <input type="checkbox"/>	Privacy Case <input type="checkbox"/>	Serious Injury <input type="checkbox"/>	Fatality <input type="checkbox"/>
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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 ____/____/____ 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

11. Status: Fulltime Part-time Temporary Non-Employee Student Visitor

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 appropriate [Incident Description Statement Form\(s\)](#).)*

15 Location of Incident include building and room number, state if outdoors :
(An example would be: Injury occurred at Engineering Sciences Building , 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 _____ Date _____

Supervisor's Name _____ Signature _____ Date _____

Reviewer's Name _____ Signature _____ Date _____

(EHS use only) Healthcare needlestick injuries only: Sharps Injury: _____

RETURN COMPLETED FORM TO: West Virginia University-Environmental Health and Safety
 Fax (304) 293-57257 or mail
 Attn: Injury/Illness Prevention Program
 PO Box 6551 Morgantown, WV 26506-6551

West Virginia University – Environmental Health and Safety

INCIDENT DESCRIPTION STATEMENT FORM

Supervisor, Injured Employee, and Witness complete a separate Statement 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) 293-57257 or mail Environmental Health and Safety Injury/Illness Prevention Program, PO Box 6551, Morgantown, WV 26506