**Accident/Incident Report**

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

<table>
<thead>
<tr>
<th>Name of Reporting Office</th>
<th>Date of Report</th>
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</thead>
<tbody>
<tr>
<td>Name of Responsible Virginia Tech Representative</td>
<td></td>
</tr>
<tr>
<td>Address of VT Office</td>
<td>State Zip Phone</td>
</tr>
<tr>
<td>Name of Injured Person(s) or Involved Person(s)</td>
<td>Age Sex</td>
</tr>
<tr>
<td>Address</td>
<td>State Zip Phone</td>
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<tr>
<td>Address</td>
<td>State Zip Phone</td>
</tr>
<tr>
<td>Name of Parent of Guardian (if minor)</td>
<td>Age Sex</td>
</tr>
<tr>
<td>Address</td>
<td>State Zip Phone</td>
</tr>
</tbody>
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Name/Address of Witnesses (Each Witness Should Attach a Signed Statement of What Happened):

1. 
2. 
3. 

Type of Incident:  
- Behavioral
- Accident
- Illness
- Other

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

Describe the Incident in Detail

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What Activity was the Injured Participating in at the Time of the Incident?

____________________________________

Describe any Equipment/Property Involved in the Incident

______________________________________________

Location of Incident: _______________________________________

Diagram Showing Objects and Persons


Describe Emergency Procedures Followed as a Result of this Incident:

____________________________

MEDICAL REPORT OF INCIDENT

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: _______________________

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

By Whom? ___________________________ Title ___________________________ When ___________________________

Response of Individual Notified ___________________________

Prognosis of Injured at the Time of Report: ___________________________
Is there anything else we should know about this incident? ____________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

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 MEDICAL TREATMENT.

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 THE ORIGINAL MAILED THE VIRGINIA TECH OFFICE OF RISK MANAGEMENT.