

PIERPONT COMMUNITY & TECHNICAL COLLEGE

STUDENT/VISITOR INJURY & ILLNESS FORM

This form should be completed by the student, supervising adult or visitor following all accidents, or incidents that occur within the schools jurisdiction or purview that:

1. Results in the injury of a student, or visitor.
2. Results in property damage.
3. Involves a student at a practicum or on any trip directly related to the students program at the institution.
  - a. Students on internships are under the employment of a company and are subject to that company's injury reporting procedures.

Please complete the following form with as much detail as possible. Attach additional pages as necessary, including reports from witnesses. When completed please call Steve Leach at 304-367-4851 or Vicki Hedrick at 304-3674692 then forward the form to Human Resources located at Advanced Technology Center (ATC) Room 200L 500 Galliher Drive Fairmont, WV within 24 hours. Please retain a copy for your records.

Status: <input type="checkbox"/> Student <input type="checkbox"/> Visitor	Date of accident/incident: (MM/DD/YYYY)	Time of accident/incident: AM PM
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Name: (Last, First MI)

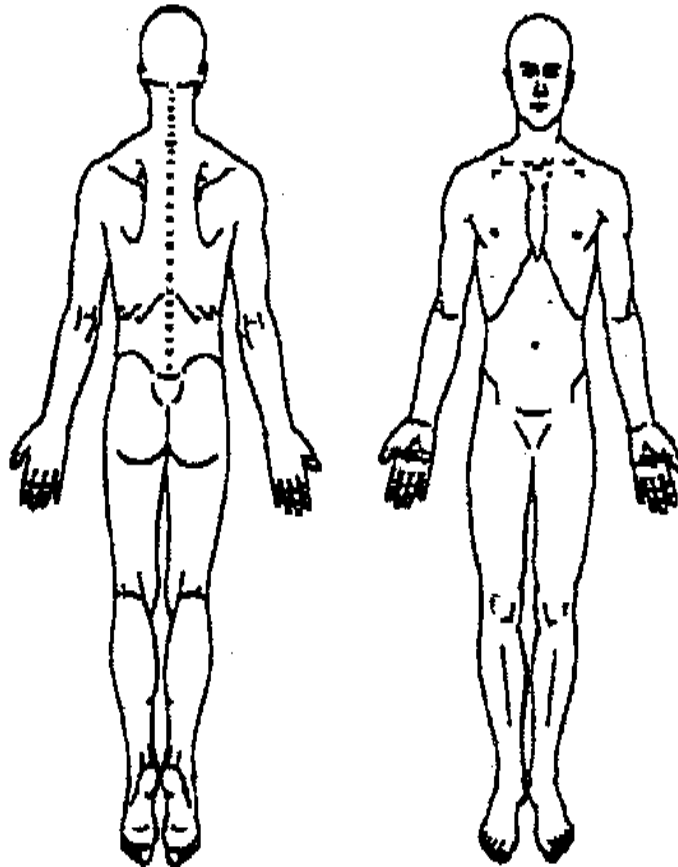
Phone Number:	Email Address:
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Address:	City:	State:	Zip Code:
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Accident/Injury location: (e.g. building, floor and room)

**Body Part(s) Injured (Check ALL that apply AND circle the areas on the body diagram provided):**

- |                                      |                                       |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Arm         | <input type="checkbox"/> Head         |
| <input type="checkbox"/> Abdomen     | <input type="checkbox"/> Hip          |
| <input type="checkbox"/> Ankles      | <input type="checkbox"/> Internal     |
| <input type="checkbox"/> Back        | <input type="checkbox"/> Knees        |
| <input type="checkbox"/> Chest Ribs  | <input type="checkbox"/> Legs         |
| <input type="checkbox"/> Ears        | <input type="checkbox"/> Mouth/ Teeth |
| <input type="checkbox"/> Elbow       | <input type="checkbox"/> Neck/ Throat |
| <input type="checkbox"/> Eyes        | <input type="checkbox"/> Nose         |
| <input type="checkbox"/> Face        | <input type="checkbox"/> Pelvis       |
| <input type="checkbox"/> Feet        | <input type="checkbox"/> Shoulder     |
| <input type="checkbox"/> Fingers     | <input type="checkbox"/> Skin         |
| <input type="checkbox"/> Full Body   | <input type="checkbox"/> Toes         |
| <input type="checkbox"/> Groin       | <input type="checkbox"/> Wrist        |
| <input type="checkbox"/> Hand        |                                       |
| <input type="checkbox"/> Other _____ |                                       |



**Type of Injury (Check all that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> Abrasion          | <input type="checkbox"/> Death               |
| <input type="checkbox"/> Amputation        | <input type="checkbox"/> Dislocation         |
| <input type="checkbox"/> Burn              | <input type="checkbox"/> Fracture            |
| <input type="checkbox"/> Chemical reaction | <input type="checkbox"/> Puncture            |
| <input type="checkbox"/> Crush             | <input type="checkbox"/> Shock/electrocution |
| <input type="checkbox"/> Cut/ Laceration   | <input type="checkbox"/> Sprain/ Strain      |

<http://www.docstoc.com/docs/23694266/Regional-Community-Services-Incident-Report>

Please provide in as much detail as possible, a description of the accident/incident. Also, please provide names of witnesses (witness statements may be attached to this form).

Was first-aid rendered?    Yes    No

Have medical services been rendered to the Student/Visitor?  Yes  No  
If yes, please list location and by who:

Student/Visitor Signature:

Date:

Contact information (if completed by someone other than the injured)

Name:

Phone Number:

Faculty/Staff Signature:

Date:

FOR INTERNAL USE ONLY

Received Date:

Received By:

Signature: