ACCIDENT / INCIDENT REPORT FORM
VIRGINIA TECH - OFFICE OF RISK MANAGEMENT BLACKSBURG, VA. 24061 Mail Code 0310
540-231-7439 riskmanagement@vt.edu

Name of Reporting Office ________________________________ Date of Report ________________

Name of Responsible Virginia Tech Representative _______________________________________

Address of VT Office __________________________________________________________________ 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. ________________________________

Type of Incident : Behavioral Accident Illness Other

Date of Incident/Accident: Day _______ Month ________________ Year _________ Time ________ (am or pm)

Describe the Incident in Detail

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

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 UNCONSCIOUSNESS, 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.