Virginia Commonwealth University
Incident Report

Campus _____ Address _____

Department _____ Specific Location _____

_____

Name of Injured _____ Address _____

Phone _____ _____

_____

Status (i.e. Patient, Visitor, Student, Other) _____

Describe Incident in Detail (How it occurred, injuries sustained, action taken, etc.) _____

_____

_____

_____

_____

_____

_____

_____

Who was notified? _____

Was anyone else involved? (Include name, address, phone number of witnesses) _____

_____

_____

_____

List any other pertinent facts _____

_____

_____

Person Initiating Report _____

Title _____ Date _____

Forward one copy of this report to: **VCU Risk Management**
PO Box 843040
Fax: 804-828-8510

****** This form is not to be used for reporting employee injuries that are subject to workers compensation ******