VCU Human Resources

VCU Volunteer Injury/Accident Report Form

This section to be completed by the injured volunteer

Print Name _____
(LAST) (FIRST) (MI)

Daytime Phone / Email Address _____

Mailing Address _____

City, State, Zip _____

Name of Principal Investigator _____

Department _____

Name of Supervisor _____

Date of Injury _____ Time of Injury _____ a.m. / p.m.

Location where injury occurred _____

Describe the accident (describe in detail how and why the injury occurred): _____

_____

_____

MEDICAL INFORMATION:

Was first aid given? [ ] Yes [ ] No

Did you seek medical treatment? [ ] Yes [ ] No

If yes, name of physician who treated you for your injury _____

Volunteer Signature _____ Date _____

This section to be completed by the volunteer's supervisor

When did you first learn of the accident? _____

How could this accident have been prevented? _____

_____

Based on your investigation, what was the cause of the accident' _____

_____

Supervisor Signature _____ Date _____

Once form is completed:

- Send **original** to volunteer's supervisor.
- Send **copy** to VCU Safety and Risk Management, Box 842501 or email to srm@vcu.edu.