



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 _____ **Date** _____
Signature _____

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 _____ **Date** _____
Signature _____

Once form is completed:

- Send **original** to volunteer's supervisor.
- Send **copy** to David Mattox, VCU Risk and Insurance Management, Box 843040.