**STUDENT INJURY REPORT**

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| PERSONAL INFORMATION: |
| **X** STUDENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E#:  | HOME PHONE | CELL PHONE/WORK PHONE |
| NAME:  |
| ADDRESS (STREET & NO.) | CITY / STATE | ZIP CODE | EMAIL ADDRESS |
| NAME OF PROGRAM / DEPARTMENT☐ AT ☐ OT ☐PA ☐ PT ☐NURSING ☐PHARMACY ☐RESPIRATORY CARE | ☐UNDERGRAD PROGRAM**X** GRADUATE PROGRAM☐CERTIFICATE PROGRAM | YEAR IN STUDY:☐1ST☐2ND ☐ 3RD ☐4TH  |
| INCIDENT / DAMAGE DETAILS:COMPLETE THIS SECTION FOR PERSONAL INJURIES: |
| PRIMARY BODY PART AFFECTEDRIGHT or LEFT☐☐HEAD☐☐NECK☐☐SHOULDER☐☐ARM☐☐ELBOW☐☐WRIST☐☐HAND☐☐FINGER(S)☐☐CHEST☐☐HIP☐☐LEG☐☐KNEE☐☐ANKLE☐☐FOOT☐☐TOE(S)☐☐OTHER | SEVERITY OF INJURY☐ NO REPORTED INJURY☐MINOR FIRST-AID☐ SEVERE NON-DISABLING☐ DISABLING. | CAUSE OF INJURY (BE SPECIFIC)☐ OBJECT (MACHINERY)☐EQUIPMENT / TOOLS☐HAZARDOUS SUBSTANCE☐NEEDLE STICK☐BODY FLUID EXPOSURE☐FALL☐OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | TREATED BY☐EMERGENCY ROOM☐PRIMARY CARE PHYSICIAN☐ OTHER\_Urgent Care☐REFUSED TREATMENT |
| LOCATION / ADDRESS OF INJURY | ADDITIONAL BODY PART(S) AFFECTED: No |
| DESCRIPTION OF INJURY: |
| WITNESS OF INCIDENT REMARKS and NAME(s): |
| CLINICAL SUPERVISOR’S REMARKSNAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: 2/19/15 |
| REPORT COMPLETED BY: PHONE: EMAIL  | DATE REPORTED | TIME REPORTEDAMPM |

**E-MAIL COMPLETED REPORT TO**

Melissa Cloyd, MPA | Information Research Technician II / Clinical Education Information Coordinator

cloydmc@etsu.edu | Phone: 423.439.8707

A copy of this form is kept by the program in the student’s file and sent to the Dean of CCHRS.