UVU INJURY / ACCIDENT REPORT FORM

Email To: Risk Management | riskmanagement@uvu.edu | (801) 863-5972
PLEASE COMPLETE ALL INFORMATION

INJURED PERSON

Name (last, first, middle):	Date of Birth:	UVU Police # (if known):	Health/Safety # (if known):
Address (including zip code):	UVU ID Number:	Work Phone:	Home Phone:
	Employment Status: Full-Time ☐ Part-Time ☐ Student ☐	Sex: M ☐ F ☐	Marital Status: Single ☐ Married ☐
Occupation / Job Title:		Status: Current UVU Student ☐ UVU Employee ☐ Visitor to UVU ☐	

UVU employees must contact a Workman's Compensation Representative in Human Resources as soon as possible! (801) 863-8389
For any accident or injury contact UVU Department of Health and Safety @ (801) 863-7977

ACCIDENT / INJURY INFORMATION

Date the accident / injury occurred?		Time the accident / injury occurred?	Date UVU was notified and who was contacted?	
Were you Injured in a UVU Class? Yes ☐ No ☐ If so, please indicate teacher and class?		Were you injured on Campus? Yes ☐ No ☐ Or in a UVU Sponsored activity? Yes ☐ No ☐	Were you injured during a physical education activity in a class, intramurals, clubs, sports, or an intercollegiate sport? Yes ☐ No ☐ Indicate activity / sport?	
Where did the accident occur?			Department or location where the accident occurred?	
What type of injury did you sustain?			What part of your body was injured?	
List witnesses that saw the accident happen:			List witnesses phone numbers:	
Were safeguards or safety equipment provided? Yes ☐ No ☐		Were they used? Yes ☐ No ☐	Has Risk Management been contacted? (Phone: (801) 863-5972) Yes ☐ No ☐	
What was the specific activity your were engaged in when the accident occurred?		List all equipment, materials, or chemicals involved in the accident:	Was the incidence caused by any person our outside company besides UVU? Yes ☐ No ☐ If so, list:	
Date of your first medical treatment?	Was this a work-related injury? Yes ☐ No ☐	Was an ambulance needed? Yes ☐ No ☐	Was treatment refused? Yes ☐ No ☐	Were you hospitalized? Yes ☐ No ☐

In your own words, please give a full description of how and when your accident / injury occurred (include witnesses, circumstances, objects, substances, etc. THIS FIELD MUST BE COMPLETED, use the back of this form if necessary):

Who was the attending first responder?	Who was the attending emergency medical provider?

INSURANCE

Name of the person your primary insurance is listed under?		Name of your primary insurance carrier?	
Phone number of your primary insurance carrier?		Primary insurance carrier's address? (include city, state, and zip code)	
Did you have the REQUIRED primary insurance coverage?		Did you have a primary insurance carrier? (as an insured or dependent)	
Insurance group number:	Insurance policy number:	Have you filed a claim with your insurance carrier? Yes ☐ No ☐	Did you receive medical services from a provider authorized by your insurance carrier? Yes ☐ No ☐

RELEASE

Injured person's signature:	Date:
Signature and Title of University Official:	Date: