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.)_____

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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