

WESTERN TEXAS COLLEGE
STUDENT / VISITOR INJURY REPORT

Date _____

This form must be completed within 24 hours of the incident. A copy shall be forwarded to the appropriate college official and a copy will be on file with the Director of Safety and Security.

Name of Injured _____ Address _____

Phone number _____

Was the injured a student or visitor? STUDENT VISITOR

Describe how the accident occurred; use an additional sheet if necessary:

Give nature and extend of injury:

Give names of witnesses to injury (also address/phone numbers)

Was the injured examined or treated by a doctor? YES NO If so, Date _____

Name of Doctor _____ Address _____

Was the injured hospitalized? YES NO Name of Hospital _____

Was the injured treated in the emergency room? YES NO Name _____

Date hospitalized or treated in ER _____ Time _____

Remarks and recommendations:

Date _____

Name _____

Name _____

Sign – Person Filing out Report

Sign – Department Head