ASHEVILLE-BUNCOMBE TECHNICAL COMMUNITY COLLEGE
INJURY REPORT FORM

ALL INCIDENTS MUST BE REPORTED TO A-B TECH POLICE WITHIN 24 HOURS

				OCA:
INCIDENT:		DATE:		TIME:
REPORTING PERSON:		TITLE:		
LOCATION:				
INJURED PARTY NAME:				
ADDRESS:		CITY:	STATE:	ZIP:
COLLEGE ID NUMBER:	DOB:	RACE:	☐ MALE ☐ FEMALE	PHONE:
IS THE INJURED PARTY: ☐ STUDENT ☐ STAFF/FACULTY ☐ VISITOR				
IF STAFF MEMBER: WHAT TIME OF DAY DID THEY BEGIN WORK: am ☐ pm ☐ WHAT IS THEIR DATE OF HIRE?		IF STUDENT: WHAT IS THEIR CURRICULUM?		

INCIDENT DATA

WHAT WAS THE PERSON DOING JUST BEFORE THE ACCIDENT OCCURRED? *Describe the activity as well as the tools, equipment or materials the person was using. Be specific. Example: Carrying materials while climbing a ladder.*

WHAT HAPPENED? *Tell how the injury occurred. Example: person fell 15 feet to the ground.*

WHAT WAS THE INJURY OR ILLNESS? *Tell the part of the body that was affected and how it was affected. Be specific. Example: Landed on left side of body. Bruised left arm above elbow and left hip.*

WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE PERSON? *Be specific. Example: Concrete floor.*

TREATMENT

WAS FIRST AIDE RENDERED? ☐ YES ☐ NO

AID GIVEN BY:

WAS THE PERSON TREATED IN A MEDICAL FACILITY OR EMERGENCY ROOM? ☐ YES ☐ NO
TRANSPORTED TO:

TRANSPORTED BY:

WAS THE PERSON HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☐ YES ☐ NO

BLOODBORNE PATHOGEN EXPOSURE? ☐ YES ☐ NO

WERE POST EXPOSURE LABS DRAWN? ☐ YES ☐ NO (SOURCE PATIENT EXPOSURE DETAILS WILL BE LINKED TO STUDENT.)

DID THE PERSON DIE? ☐ YES ☐ NO

IF THIS PERSON DIED, WHEN DID DEATH OCCUR?

ADDITIONAL DETAILS:

SIGNATURE OF FACULTY / STAFF REPORTING INFORMATION:	DATE:

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE ANY HEALTH CARE PROVIDER, INSURANCE COMPANY, EMPLOYER, PERSON OR ORGANIZATION TO RELEASE INFORMATION REGARDING MEDICAL, DENTAL, MENTAL, ALCOHOL OR DRUG ABUSE HISTORY, TREATMENT OR BENEFITS PAYABLE, INCLUDING DISABILITY OR EMPLOYMENT RELATED INFORMATION, TO ASHEVILLE-BUNCOMBE TECHNICAL COMMUNITY COLLEGE, OR ITS EMPLOYEES AND AUTHORIZED AGENTS, FOR THE PURPOSE OF RISK MANAGEMENT. A PHOTO COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

_____ _____ _____

INJURED PARTY SIGNATURE | WITNESS SIGNATURE | DATE AND TIME

MEDICAL TREATMENT REFUSAL

(TO BE READ TO INJURED PARTY)

THE INJURED PARTY HAS BEEN INFORMED OF THE NEED TO SEEK MEDICAL TREATMENT. AVAILABLE MEDICAL FACILITIES INCLUDE: MY CARE NOW (310 LONG SHOALS RD. ARDEN, NC 28704 -- MONDAY-SUNDAY / 7:00AM-10:00PM), EMERGENCY ROOM, OR PERSONAL PROVIDER.

I, _____, REFUSE MEDICAL TREATMENT AND/OR TRANSPORTATION TO A MEDICAL FACILITY AND UNDERSTAND THAT BY REFUSING TREATMENT, I ACCEPT FULL RESPONSIBILITY FOR MY ACTIONS/DECISIONS.

_____ _____ _____

INJURED PARTY SIGNATURE | WITNESS SIGNATURE | DATE AND TIME

STUDENT INJURIES

UPON TREATMENT, STUDENTS MUST CONTACT A-B TECH RISK MANAGEMENT TO GENERATE A CLAIM UNDER THE STUDENT INSURANCE POLICY.

RE: STUDENT INJURY / EXPOSURE INCIDENT
ATTN: SHELBY BURNETT, A-B TECH RISK MANAGEMENT
PHONE: 828-398-7109
SHELBYTBURNETT@A-B TECH.EDU

EMPLOYEE INJURIES

UPON TREATMENT, EMPLOYEES MUST CONTACT A-B TECH HUMAN RESOURCES TO COMPLETE A WORKPLACE ACCIDENT REPORTING PACKET FOR WORKERS COMPENSATION.

ATTN: CRYSTAL SAVELL, BENEFITS SPECIALIST
PHONE: 828-398-7168
CRYSTALMSAVELL@A-B TECH.EDU