Kirkwood
COMMUNITY COLLEGE

Student and Visitor Injury Report

To be completed by injured student/visitor: Student ☐ Visitor ☐

Name: _____ DOB: _____ k-number: _____

Home Address: _____ Phone: _____

Emergency Contact: _____

Date/Time of Injury: _____

Notified/Witnessed By: _____

Location Where Injury Occurred: _____

Describe Nature of Injury:

Ambulance Called: Yes ☐ or No ☐ Time: _____

Transferred to Hospital Via Ambulance: Yes ☐ or No ☐ Time: _____

Did You Seek Medical Treatment: Yes ☐ or No ☐

Student Signature: _____ Date: _____

Print Name: _____

To be completed by student's supervisor or faculty member (ex. lab tech, work study, preceptor):

Name: _____

Phone: _____ Job Title: _____

Date/Time of Injury: _____

Location Where Injury Occurred: _____

Describe How Accident Occurred:

Follow Up Action Needed or Corrective Actions Needed?

Signature: _____ Date: _____

Print Name: _____

To be completed by witness (if applicable):

Name: _____

Phone: _____

Date/Time of Injury: _____

Location Where Injury Occurred: _____

Describe How Accident Occurred:

Signature: _____ Date: _____

Print Name: _____

Please send completed reports to Director, Risk Transfer at risk@kirkwood.edu within 48 hours.