

UTMB Student Accident and Injury Report Form

DO NOT USE THIS FORM TO REPORT EXPOSURES TO BLOODBORNE PATHOGENS

Name: _____ Student ID #: _____
Last First MI

Address: _____

Home phone #: _____ Pager or cell phone #: _____

School: _____ Program: _____

Date of injury: _____ Time of injury: _____ AM PM

Injury location: _____
Building Floor Room Number

Brief description of what happened:

Body Part Affected

X	Mark Appropriately	X	Mark Appropriately	R	L
	Head		Eye		
	Face		Shoulder		
	Neck		Arm		
	Chest		Hand		
	Stomach		Finger		
	Back (lower)		Leg		
	Back (upper)		Knee		
			Ankle		
			Foot		
			Toe		

Item or equipment involved in accident or injury: _____

Witnesses (name & title): _____

INFORMATION RELEASE

By signing this report form, I understand that I am giving my authorization to UTMB and Student Wellness' designated medical records custodians or database custodians to use and/or disclose my protected health information for the purpose of reviewing the accident/injury reported on this form for determining necessity of medical care and possible reimbursement by third party payers.

Signature of student: _____ Date: _____

**Return completed form to Student Wellness route 0169.
 Call 409-747-9320 with any questions.**