INJURED PERSON [fills out this section]

Last Name First E u Middle] v] š] 'ò E µ u or CSSN (last 4 digits) Birth Date

Street City State Zip

Phone # (_____) _____ Check One: ☐ Student ☐ Employee ☐ Public ☐ Child Care

Location of incident:

WV___ MC___ Building/Room _____ Date of Incident _____ Time _____

(Other location, please describe or attach maps)

For accidents in class or lab activities:

Instructor Name Course name

Other Witness/es Name(s)