

Texas A&M HSC College of Medicine Student Accident and Needlestick Injury Report Form

Name: _____ Student ID # _____
Last First MI

Home Address: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Faculty Supervisor: _____ Phone: (____) _____ Ext. _____

Campus Location: Bryan-College Station Temple Round Rock Dallas Houston

Current Rotation: I Med F Med Pedi Ob-Gyn Psych Surgery EM Other _____

Injury Date: _____ Time of Injury: _____

What facility/hospital/clinic and room? _____

Body part affected <input type="checkbox"/> Head <input type="checkbox"/> Eye <input type="checkbox"/> Face <input type="checkbox"/> Neck <input type="checkbox"/> Chest/lungs <input type="checkbox"/> Abdomen <input type="checkbox"/> Back (upper) <input type="checkbox"/> Back (lower)	Body part: <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Hand <input type="checkbox"/> Finger <input type="checkbox"/> Leg <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot/ toe	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%;">L</td> <td style="width: 50%;">R</td> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>		L	R																												Type of injury: <input type="checkbox"/> Aerosol exposure <input type="checkbox"/> Skin / eye splash <input type="checkbox"/> Abrasion <input type="checkbox"/> Needle puncture <input type="checkbox"/> Laceration <input type="checkbox"/> Other _____
	L	R																															

Provide brief description of reported injury / exposure:

What personal protective equipment was used at the time of the injury/exposure incident?
 gloves: latex other: _____ eye protection face shield
 type of mask/respirator: _____ type of protective clothing: _____

List any item or equipment involved in accident? _____
 Did any equipment malfunction at the time of the injury/exposure? No Yes NA

List the facility where initial evaluation/ treatment was given: _____
 Did the facility waive the cost of initial evaluation/ treatment? yes no
 Did the facility accept the student's insurance? yes no

Date information entered on this form: _____

Mail or fax this form to your campus student services coordinator and Office of Student Affairs.