utmb Health
School of Health Professions

Reset Form

Print Form

# Student Accident & Injury Report Form - SHP

**Students**: Please provide all information requested. This form can be completed electronically, but must be printed with an original signature before turning it in to Student Health, your department, and SHP Academic & Student Affairs (room 4.224). Problems with the form can be directed to **shp.academicaffairs@utmb.edu**.

Student Name: _____ _____ _____
Last First Middle

Student ID#: _____ Department: Choose One

Date of Injury: _____ Time of Injury: _____ ☐ AM ☐ PM

Injury Location: _____
Building Floor Room Number

Brief description of what happened:

Body Part Effected:

| | Mark Appropriately |
|---|---|
| ☐ | Head |
| ☐ | Face |
| ☐ | Neck |
| ☐ | Chest |
| ☐ | Stomach |
| ☐ | Back (lower) |
| ☐ | Back (upper) |

| | Mark Appropriately | R | L |
|---|---|---|---|
| ☐ | Eye | ☐ | ☐ |
| ☐ | Shoulder | ☐ | ☐ |
| ☐ | Arm | ☐ | ☐ |
| ☐ | Hand | ☐ | ☐ |
| ☐ | Fingers | ☐ | ☐ |
| ☐ | Leg | ☐ | ☐ |
| ☐ | Knee | ☐ | ☐ |
| ☐ | Ankle | ☐ | ☐ |
| ☐ | Foot | ☐ | ☐ |
| ☐ | Toe | ☐ | ☐ |

Item or equipment involved in accident or injury: _____

Witnesses:
(include
name & title)

## INFORMATION RELEASE:

By signing this report form, I understand that I am giving my authorization to UTMB and Student Health's 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 Health, Route 1369 or fax to (409) 747-9330 or scan and email to stdwappt@utmb.edu. Please also provide your department and SHP Academic & Student Affairs (room 4.224) with a copy.
Call 409-747-9508 with any questions.