

**CITY OF HAMPTON
HAMPTON CITY SCHOOLS
VIR FORM 4000
VOLUNTEER INCIDENT REPORT
(Revised October 2014)**

**NOTE: PLEASE FORWARD REPORT TO
RISK MANAGEMENT AND SAFETY**

Volunteer					
Name of Volunteer (Last, First, Middle)			Last four of SS Number		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Location of Incident			Date of birth		Volunteering or Visiting?
Home Address		City	State	Zip Code	Volunteer Start Date
Time and Place of Injury/Illness					
Location where incident occurred		Date of injury or illness		Hour of injury or illness a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
				Time began a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
Date injury or illness reported		Person to whom reported		Name of other witness	
				If fatal, give date of death	
Incident Type			Injury Type		
<input type="checkbox"/> Animal Bite <input type="checkbox"/> Caught In /On / Between <input type="checkbox"/> Fall Same Level <input type="checkbox"/> Fall Different Level <input type="checkbox"/> Illness <input type="checkbox"/> Insect Bite			<input type="checkbox"/> Lifting <input type="checkbox"/> Push/Pull <input type="checkbox"/> Slip/Trip <input type="checkbox"/> Struck Against/By <input type="checkbox"/> Temperature Other		
<input type="checkbox"/> Abrasion <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Cut/Puncture Other			<input type="checkbox"/> None <input type="checkbox"/> Skin Rash <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Fracture		
Body Part Affected					
<input type="checkbox"/> Left <input type="checkbox"/> Right / <input type="checkbox"/> Abdomen <input type="checkbox"/> Groin <input type="checkbox"/> Toes <input type="checkbox"/> Hand <input type="checkbox"/> Ankle <input type="checkbox"/> Wrist <input type="checkbox"/> Arm <input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Hip <input type="checkbox"/> Chest <input type="checkbox"/> Knee <input type="checkbox"/> Ear <input type="checkbox"/> Leg <input type="checkbox"/> Elbow <input type="checkbox"/> Mouth <input type="checkbox"/> Eye <input type="checkbox"/> Neck <input type="checkbox"/> Face <input type="checkbox"/> Nose <input type="checkbox"/> Shoulder <input type="checkbox"/> Other					
Employee's Action					
<input type="checkbox"/> Bending <input type="checkbox"/> Driving <input type="checkbox"/> Riding <input type="checkbox"/> Running <input type="checkbox"/> Sitting <input type="checkbox"/> Squatting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Other					
Surface Type					
<input type="checkbox"/> Brick <input type="checkbox"/> Dirt <input type="checkbox"/> Stone <input type="checkbox"/> Carpet <input type="checkbox"/> Grass <input type="checkbox"/> Tile <input type="checkbox"/> Concrete <input type="checkbox"/> Pavement <input type="checkbox"/> Wood <input type="checkbox"/> Other					
Volunteer's Version of How Incident Occurred					
Volunteer: (name, signature, title)			Date		Phone Number
Supervisor's Comment					
SUPERVISOR: (name, signature, title)			Date		Phone Number