Walters State Community College
Personal Injury / Illness / AED Use
(Complete one report per victim.)

ADMINISTRATIVE

Incident Number: | **Date:** | **Time:** | **Report is:** ☐ Injury ☐ Illness ☐ Weather Related ☐ AED Use ☐ Other: (specify)

Report Completed By: ☐ Campus Police Officer ☐ Other ☐ WSCC Staff/Faculty ____________________

Please Print Name of Person Completing Report:

Location: ☐ Morristown/Hamblen Co. ☐ Greeneville/Greene Co. ☐ Sevierville/Sevier Co. ☐ Tazewell/Claiborne Co. ☐ Expo Center, White Pine/Jefferson Co. ☐ Other Location ______________________________

Building: | **Room:** | **Parking Area:** | **Other Area:**

VICTIM / PATIENT INFORMATION
☐ Identifying Information Not Available at Time of Report

Victim/Patient Initial Assessment:
☐ Conscious ☐ Unconscious ☐ Breathing ☐ Not Breathing
☐ Pulse ☐ No Pulse ☐ AED Used ☐ CPR
☐ 911/EMS Notified - Rescue Started

Check One: ☐ Student ☐ Visitor ☐ Employee

Date of Birth:

Gender: ☐ Male ☐ Female

Age:

Class Attending: | **Instructor:** | **Location:** ☐ Present ☐ Not Present

If Visiting for What Purpose?

If Employee: Were You Performing Official Work Related Duties During Regular Business Hours? ☐ Yes ☐ No

Employee's Supervisor's Name:
*OSHA Form 301 must be completed by supervisor. You may obtain this form from the Human Resource Office.

Department:

Victim's Full Name (FML):

Street Address: | **City:** | **State:** | **Zip:**

WID: | **DL:** | **State:** | **Other ID:**

Emergency Contact Name: | **Telephone Number:**

Emergency Contact: ☐ Made ☐ Attempted | **Time:** | **By:**

EMERGENCY SERVICES NOTIFICATIONS

☐ **Campus Police**	**Time Notified:**	**Time of Arrival:**
☐ **911/EMS/Rescue**	**Time Notified:**	**Time of Arrival:**

TREATMENT / FURTHER CARE

Patient Refused Treatment: ☐ Yes ☐ No
(Complete refusal of care on back)

Transported To:

RESCUE INFORMATION

If AED Used:
☐ Yes ☐ No Shock Delivered Number of Shocks ____
☐ Yes ☐ No Pulse Returned
☐ Yes ☐ No Breathing Returned
☐ Yes ☐ No Consciousness Returned
☐ CPR Performed
By: ______________________________
☐ Yes ☐ No Oxygen Used/Applied

☐ Additional Shocks Needed Number ____
☐ Yes ☐ No Pulse Returned
☐ Yes ☐ No Breathing Returned
☐ Yes ☐ No Consciousness Returned

Condition Upon Arrival of EMS:
☐ Conscious ☐ Unconscious ☐ Breathing ☐ Not Breathing
☐ Pulse ☐ No Pulse ☐ AED Used ☐ CPR
☐ Rescue Turned Over to EMS Time: ______________________________

Signature of Person Performing Rescue:

WITNESSES

☐ Witness Statements Attached ☐ Witness Left Scene - Not Identified ☐ No Witness Present

Witness 1 - Full Name (FML)	**Witness 2 - Full Name (FML)**
Street Address:	**Street Address:**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
SID or DL:	**SID or DL:**
Telephone Number:	**Telephone Number:**

AREA INSPECTION RESULTS

Visual Inspection Only of Area: ☐ Yes ☐ No **By:** ____________ **Date/Time:** ____________ **Statement Attached:** ☐ Yes ☐ No
Photographs Taken of Area: ☐ Yes ☐ No **By:** ____________ **Date/Time:** ____________ **Statement Attached:** ☐ Yes ☐ No
Photographs Taken of Injury: ☐ Yes ☐ No **By:** ____________ **Date/Time:** ____________ **Statement Attached:** ☐ Yes ☐ No

AREA TYPE
☐ Indoor Floor ☐ Indoor Stairs/Stairwell ☐ Outdoor Sidewalk
☐ Outdoor Sidewalk Stairs ☐ Outdoor Parking Area ☐ Outdoor Curb
☐ Other ______________________________

TYPE OF SURFACE
☐ Tile Flooring ☐ Carpeted Flooring ☐ Concrete Flooring
☐ Wood Flooring ☐ Pavement/Asphalt ☐ Grass/Ground
☐ Gravel ☐ Concrete
☐ Other ______________________________

CONDITION OF AREA
(Check all that apply)
☐ No Visible Defects ☐ No Obstruction or Debris ☐ Dry
☐ Wet ☐ Moderately Wet ☐ Excessively Wet
☐ Ice/Snow Present ☐ Surface Broken/Cracked ☐ Carpet Torn/Frayed
☐ Other (Described in Narrative)

TIME OF DAY
☐ Daylight ☐ Dusk
☐ Dawn ☐ Night/Dark

LIGHTING
☐ Indoor ☐ Outdoor
☐ On ☐ Off ☐ Not Working
☐ Damaged ☐ Well Lit ☐ Adequately Lit
☐ Poorly Lit ☐ Dimly Lit ☐ None Present

continued on back

HISTORY OF ACCIDENT / NATURE AND EXTENT OF INJURY

(Injured Should Complete When Possible, Mention All Circumstances Before, During and After Accident, Attach Additional Sheet if Needed)

CAMPUS POLICE OR OTHER STAFF ASSESSMENT AND ACTION TAKEN

Outcome If Known: ☐ Survival ☐ Death

Patient Signature ____________________________ Date ____________

Signature of Person Completing Report ________________________ Date ____________

Reviewed By ____________________________ Date ____________

REFUSAL OF CARE

CRITERIA FOR REFUSING MEDICAL CARE

The patient meets all of the following:

1.Is a patient 18 years or older.

2.Exhibits no evidence of:
- altered level of consciousness
- alcohol or drug ingestion that would impair judgment.

3. Understands the nature of the medical condition, as well as the risks and consequences of refusing care.

1. **Acknowledgment of Information**
   - I have been advised that medical care on my behalf may be necessary and that refusal of care and assistance could be detrimental to my health. I acknowledge that I may have a medical problem which may require additional medical attention, and that emergency medical services is available or may be called to transport me to the hospital. Instead, I elect to seek alternative medical care and/or refuse further evaluation, treatment, and/or transport.

2. **Release of Liability**
   - By signing this form, I am releasing Walters State Community College of any liability or medical claims resulting from my decision to refuse medical care.

Signature of person refusing care: ____________________________

WALTERS STATE
COMMUNITY COLLEGE