



## ACCIDENT / INCIDENT REPORT

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Name of Injured Person: \_\_\_\_\_

Phone--Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_

Address: \_\_\_\_\_

Age of Victim (if a minor): \_\_\_\_\_ Parent Notified: \_\_\_\_\_

Location of incident: \_\_\_\_\_

Program or Event: \_\_\_\_\_

Description of Injury: \_\_\_\_\_

\_\_\_\_\_

Details of Incident: \_\_\_\_\_

\_\_\_\_\_

First Aid Steps Taken: \_\_\_\_\_

\_\_\_\_\_

If victim was taken for Medical Assistance, specify physician, facility, diagnosis, and treatment given:

\_\_\_\_\_

\_\_\_\_\_

Supervisor at time of incident: \_\_\_\_\_ Phone: \_\_\_\_\_

Witness to Incident: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of person completing report: \_\_\_\_\_ Phone: \_\_\_\_\_

Is this a Potential Work Comp Claim: \_\_\_\_\_

Other pertinent information: \_\_\_\_\_

Return completed report to the Business Manager immediately