Print Form

STUDENT/VISITOR ACCIDENT/INJURY/ILLNESS STATEMENT & INVESTIGATION FORM

Date and Time reported:_____

Full Name _____ SSN: _____
(Last) (First)

Phone #: _____

Date of Injury/Accident: _____ Time: _____ AM/PM

Exact location of accident: _____

Name of Witnesses: _____

Titles (Addresses and telephone numbers if not employees): _____

_____

Description of Illness/Injury: _____

_____

_____

_____

_____

Person received medical attention other than first aid? _____Yes ____No

Has the injured/ill party communicated any history of similar injuries or pain prior to this incident? If yes, please explain. _____

_____

Follow Up Actions/Activities:

Date: _____ Action: _____

Date: _____ Action: _____

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Ill/Injured party's description of injury (Be specific and include circumstances leading to the problem/incident). Please print.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Statement and all information provided are true and factual to the best of my knowledge.

_____ _____ _____

Printed Name of Injured Party **Signature** **Date**

_____

Phone Number

Officer Taking Report: _____ _____ _____

Printed Name Signature Date

For Public Safety Use Only:

Disposition of Claim: _____

Copies of this report forwarded to: _____

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