Attachment 4

Accident / Injury Report Form

Name: _____Sex: ___Male ___ Female
Address:
_____
Street City State Zip Code

Telephone: _____ E-Mail: _____

Date of This Report: _____ Date of Accident: _____

Time of Accident: _____a.m. ./ p.m. Place of Accident: _____

NATURE OF INJURY

Abrasion _____ Fracture _____
Asphyxiation ____ Laceration____
Bite _____ Poisoning _____
Bruise _____ Puncture _____
Burn _____ Scalds _____
Concussion ____ Scratches_____
Cut _____ Shock (el.)____
Dislocation _____ Sprain _____
Other (specify) _____

Abdomen _____Ankle (__R / __L)
Back _____ Arm (____R / ____L)
Chest _____ Ear (____R / ____L)
Face _____ Elbow (_R / _L)
Finger _____ Eye (__R /__L)
Head _____ Foot (_R / __L)
Mouth _____ Hand (__R /__L)
Nose _____ Knee (__R /_L)
Scalp _____ Leg (__R /__L)
Tooth _____ Wrist (_R /__L)
Other (specify)
_____

DESCRIPTION OF ACCIDENT
PART OF BODY INJURED

How did accident happen? What was the person doing? Where was the person? List any specifically unsafe acts and unsafe conditions existing? Specify any tool, machine or equipment involved? Additional space available on back

_____
_____
_____

IMMEDIATE ACTION TAKEN

First Aid Treatment Given: __ YES __ NO By Name: _____
First Aid Rendered:
_____
Sent to Hospital? ___YES ___ NO
Transported to health care facility for further examination/treatment? ___YES ___ NO
____Ambulance _____ Personal Vehicle _____ Friends Vehicle (name)
_____

1. Witness: _____ 2.Witness:_____

Address: _____Address: _____

Phone #: _____ Phone #: _____

E-Mail: _____E-Mail: _____

Form Submitted by: _____ Date: _____

Signature of Injured Party: _____ Date: _____