ACCIDENT/INJURY REPORT

DATE OF ACCIDENT:		TIME OF ACCIDENT:	
ACCIDENT BUILDING, ROOM, CAMPUS LOCATION: Accident occured: ☐ Before Class ☐ During Class ☐ After Class ☐ During Break/Lunch			
INJURED PARTY			
FULL NAME:			
HOME ADDRESS:		MAILING ADDRESS:	
CITY:	STATE: ZIP:	CITY:	STATE: ZIP:
TELEPHONE NUMBER:			
If injured party is a minor, PARENT OR GUARDIAN CONTACT INFORMATION			
PARENT/GUARDIAN NAME:			
HOME ADDRESS:		MAILING ADDRESS:	
CITY:	STATE: ZIP:	CITY:	STATE: ZIP:
TELEPHONE NUMBER:			
REASON FOR BEING ON CREATE TOGETHER CAMPUS			
COURSE ENROLLED IN:		TEACHING ARTIST NAME:	
TEACHING ARTIST OR STAFF MEMBER NAME completing the report with injured party: ☐ I am a firsthand witness to the accident.			
ADDRESS:			
CITY:	STATE: ZIP:	TELEPHONE NUMBER:	
STAFF MEMBER ON DUTY (SMOD):			
ADDRESS:			
CITY:	STATE: ZIP:	TELEPHONE NUMBER:	
WITNESS #1		WITNESS #2	
NAME:		NAME:	
ADDRESS:		ADDRESS:	
CITY:	STATE: ZIP:	CITY:	STATE: ZIP:
TELEPHONE NUMBER:		TELEPHONE NUMBER:	

DESCRIBE THE NATURE OF THE INJURY:

☐ This description is firsthand knowledge from (full name) _____
(circle one) Teaching Artist, SMOD, Witness #1, Witness #2

DESCRIBE WHAT CAUSED THE INJURY:

RESOLUTION

HOW WAS THE INJURY ADDRESSED? ☐ Used First Aid Kit ☐ Medical Attention ☐ Ambulance
(please provide details)

WAS MEDICAL ATTENTION OFFERED TO INJURED PARTY?	☐ YES ☐ NO
DID THE INJURED PARTY LEAVE CAMPUS FOR MEDICAL ATTENTION?	☐ YES ☐ NO ☐ by self-driven ☐ by personal vehicle ☐ by SMOD vehicle ☐ by ambulance
WAS A PARENT/GUARDIAN OR EMERGENCY CONTACT CONTACTED?	☐ YES ☐ NO
DID INJURED PARTY REFUSE MEDICAL ATTENTION? If YES, did the injured party sign the WAIVER OF MEDICAL ATTENTION?	☐ YES ☐ NO ☐ YES ☐ NO
TIME ACCIDENT REPORT WAS DELIVERED TO OFFICE OR STAFF MEMBER ON DUTY:	

Signature:	Date:	Staff Member on Duty
Signature:	Date:	Director
REPORTED TO INSURANCE COMPANY	Date:	BY: