

STUDENT AND PUBLIC ACCIDENT/INCIDENT REPORT

IMPORTANT: USE THE COMPANY NURSE HOTLINE (877-854-6877) INSTEAD OF THIS FORM IF the injured person is an employee, student worker, or student injured off campus during a clinical rotation (ex. nursing student in the hospital).

WHO INITIATES THIS FORM? The main employee witness or first employee aware of the accident/injury

A. INJURED PERSON

Name: _____ DOB: _____ ☐ Student
 Address: _____ ID#: _____ ☐ Visitor
 E-Mail: _____ Phone: () _____

B. DATE OF ACCIDENT (Mo/Day/Yr) ____ / ____ / ____ Time of Accident: ____ AM PM

If Student: Time classes began: ____ AM PM Time classes ended: ____ AM PM

C. LOCATION OF ACCIDENT ____ Fresno City College ____ Reedley College ____ Madera Community College

____ Clovis Community College ____ Herndon Campus ____ Oakhurst Center ____ Other: _____

Specific location on campus: _____

D. DESCRIPTION OF ACCIDENT Describe how accident occurred - may use back of form if needed

Intercollegiate Athletics injury? ____ NO ____ YES.....during: ☐ Game ☐ Practice Position Played: _____

School rules that were or may have been violated: _____

E. SUPERVISION Person supervising at time of accident: _____ Title: _____

Was this person present at time of accident? ____ YES ____ NO Phone: () _____

F. WITNESSES

Name: _____ Title: _____ Phone: () _____

Name: _____ Title: _____ Phone: () _____

G. DESCRIPTION OF INJURY

Body part(s) Injured	Apparent Nature and/or Extent of Injury	First Aid Administered	By Whom
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

H. DISPOSITION OF INJURED AFTER ACCIDENT

____ Class ____ Doctor ____ Who was notified? _____
 ____ Home ____ Hospital Relationship to injured: _____ Phone: _____
 ____ Other: _____
 ♦ Injured person released to: ____ Self (no further assistance requested)
 ____ Other (specify): _____

I. HEALTH INSURANCE STATUS (other than campus student accident insurance)

____ No Health Insurance ____ Medi-Cal Coverage ____ Private Insurance (list company): _____

J. REPORT COMPLETED BY:

Name: _____ Title: _____ Date: _____

K. REPORT REVIEWED BY DEPARTMENT SUPERVISOR:

Name: _____ Title: _____ Signature: _____ Date: ____

FORWARD COMPLETED FORM TO HEALTH SERVICES WITHIN 24 HOURS OF INJURY