Accident Report Form

The following form is used to report all accident and injuries involving employees, students, and guests that occur while on campus at The Institute of Allied Healthcare. This form must be filled out immediately and no later than 24 hours after the accident occurs. Submit completed forms to the School Director's office.

INJUR	ED PERS	ON INFORM	ATION		
Name:	DOB:				
Address:	_ City		_ State	Zip	
Phone number: Home ()		Cell ()		Work ()	
	INJUR	Y DETAILS			
Date of injury:/	Exact time of injury::am/pm				
Exact location of event:					
What part of your body was injur	red?				
Describe how the accident happen	ned? Desc	ribe in detail:			
		-			·
					
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		· · · · · · · · · · · · · · · · · · ·			
(Attach additional sheets if necess	ary)				

EMERGENCY SER	VICES
Did the injured person go to the doctor/hospital? Yes	s/No
Police called to the scene? Yes/No	
Emergency services called to the scene. Yes/No	
What actions can be taken to eliminate future repeats	s of the incident?
OFFICE PERSONNEI	L ONLY
Did the injured person refuse emergency services? Yo	es/No
Employee Signature:	Date: