# Accident Report Form

The following form is used to report all accidents 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.

| INJURED PERSON INFORMATION | | |
|---|---|---|
| Name: | | DOB: / / |
| Address: | | |
| City: | State: | Zip: |
| Phone Number: | | |

| INJURY DETAILS | | |
|---|---|---|
| Date of Injury: / / | Exact time of Injury: : | am / pm |
| Exact location of event: | | |
| What part of your body was injured? | | |
| Describe in detail how the accident happened: | | |

(See back for more)



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| EMERGENCY SERVICES |
| --- |
| Did the injured person go to the doctor/hospital? Yes / No |
| Did the Police get called to the scene? Yes / No |
| Did the Emergency Services get called to the scene? Yes / No |
| What actions can be taken to eliminate future repeats of the incident? |

**OFFICE PERSONNEL ONLY**

Did the injured person refuse emergency services? Yes / No

Employee Signature: _____ Date: _____



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