

CHABOT-LAS POSITAS COMMUNITY COLLEGE DISTRICT
ACCIDENT REPORT FORM

NAME _____ DATE OF REPORT _____

ADDRESS _____ PHONE _____

DATE OF ACCIDENT _____ TIME OF ACCIDENT _____

LOCATION OF ACCIDENT _____

If an off-campus location, was activity college-sponsored: YES NO

STATUS AT TIME OF ACCIDENT: STUDENT
 CONTRACTOR _____
Company Name
 VISITOR
 OTHER _____

What activity was being performed when the accident occurred? _____

How did the accident or injury occur? _____

Description of accident and part of the body affected (be specific): _____

Was it necessary to seek immediate medical attention? YES NO
If no, is it probable that future medical treatment will be necessary? YES NO
Did you seek the assistance of the Student Health Services? YES NO

Witnesses:

	<u>NAME</u>	<u>ADDRESS</u>	<u>PHONE</u>
1.	_____	_____	_____
2.	_____	_____	_____

Signature of Injured Person Date

FOR STUDENT HEALTH SERVICES USE ONLY	
Describe injury and part of body injured: _____	
Treatment Received: _____	
Referred: <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Class	
_____ Signature of Student Health Services	_____ Date
Follow-up: _____	

Distribution of Copies: Original- HR Office; Copy- Student Health Services; Copy- Injured Person
UPON COMPLETION OF FORM, RETURN TO HUMAN RESOURCES.