State Center Community College District - HEALTH SERVICES

STUDENT AND PUBLIC ACCIDENT REPORT

IMPORTANT: USE THE COMPANY NURSE HOTLINE (888-770-0929) 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: _____ Date of Birth: _____

Address: _____ Phone: ( ) _____

E-Mail: _____ Registered Student ? ___ NO ___ YES, ID #: _____

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 Center

___ 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

___ Home ___ Hospital

___ Other: _____

- Who was notified? _____

  Relationship to injured: _____ Phone: _____

- 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: _____

If a **VISITOR** was injured, fax form to ***CorVel Claims Specialist*** Wk: (916) 605-3884 **FAX: (866) 407-2536**

Date Faxed: _____ Time Faxed: _____ by: _____ Title: _____

FORWARD COMPLETED FORM TO HEALTH SERVICES WITHIN 24 HOURS OF INJURY

Date received by Health Services: _____ Reviewed by: _____ Date: _____