State Center Community College District - HEALTH SERVICES

# STUDENT AND PUBLIC ACCIDENT 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

___ 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: __________

## K. REPORT REVIEWED BY DEPARTMENT SUPERVISOR:

Name: ______________ Title: __________ Signature: __________ Date: __/__/__

**FORWARD COMPLETED FORM TO HEALTH SERVICES WITHIN 24 HOURS OF INJURY**

Date received by Health Services: __________ Reviewed by: ______________ Date: ________