



INCIDENT REPORT FROM: _____
(Location)

COMPLETE THIS REPORT FOR ALL INCIDENT/INJURIES. ANSWER ALL QUESTIONS. PLEASE INSERT AN "N/A" IN A SPACE WHERE THE QUESTION DOES NOT APPLY. **REPORT ALL INJURIES TO YOUR CLAIMS/RISK MANAGER AT THE CATHOLIC CENTER (817/560-2452, EXT. 167).** THIS REPORT SHOULD BE FAXED OR MAILED TO THE CATHOLIC CENTER, ATTN. CLAIMS/RISK MANAGER, 800 WEST LOOP 820 SOUTH, FORT WORTH, TX 76108 AFTER THE INCIDENT HAS BEEN REPORTED VIA THE TELEPHONE.

DATE OF INCIDENT _____ TIME _____ AM PM

SPECIFIC LOCATION _____

DETAILS OF INCIDENT: (WHAT TOOK PLACE, HOW DID IT HAPPEN, WHY DID IT HAPPEN? LIST NAMES, ADDRESSES AND PHONE NUMBERS OF ANY WITNESSES.)

NAME OF PERSON INJURED _____ AGE _____ GENDER _____

HOME ADDRESS _____

PHONE NUMBER _____

AMBULANCE CALLED _____ YES _____ NO POLICE CALLED _____ YES _____ NO

FIRE DEPT. CALLED _____ YES _____ NO TIME OF CALL _____ A.M. P.M.

IF APPLICABLE, FAMILY/PARENT NOTIFIED? YES NO TIME _____ A.M. P.M.

IN YOUR OPINION, COULD THIS ACCIDENT HAVE BEEN PREVENTED? _____ YES _____ NO

IF YES, WHY? _____

SUGGESTIONS FOR PREVENTING A SIMILAR ACCIDENT FROM TAKING PLACE _____

REPORT SUBMITTED BY:

NAME

DATE