



PARTICULARS OF ACCIDENT

PERSON INJURED INFORMATION

THE ACCIDENT

Analysis (What were the causes of the accident?)

Where vehicles involved? ☐ Yes ☐ No If Yes, Please list the following information:

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Where there any Witnesses to the Accident? ☐ Yes ☐ No If Yes, Please fill in the following information:

Witness Name

Witness Phone#

Initial Treatment (Please check one below)

☐ No Medical Needed

☐ Treated but No Clinical or Hospital Needed

☐ Treated and transported to Clinical or Hospital (if checked provide information below):

Hospital Name/Address/Phone#

Hospitalized for more than 24hrs?

IF TREATMENT WAS PROVIDED

Type of treatment given

Name of person giving Treatment

Did Treatment Improve Patients
Condition?

ACCIDENT INVESTIGATION

Accident Investigated by

Signature

Date

PREVENTION

What action has or will be taken to prevent a recurrence?

BY SIGNING BELOW YOU AGREE THAT THE INFORMATION PROVIDED IS TRUE AND ACCURATE

Signature of Volunteer

Date: