Foothill-De Anza Community College District

REPORT OF ACCIDENT / INCIDENT

☐ Employee
☐ Visitor
☐ Student

To be completed by supervisor/employee for incidents involving injury or potential injury to employees, visitors or student. Forward to the Risk Management Office in the District Office.

GENERAL EMPOYEE / VISITOR / STUDENT INFORMATION

NAME LAST	FIRST	MIDDLE	DATE OF BIRTH
HOME ADDRESS			HOME PHONE #
SOCIAL SECURITY #	DEPARTMENT	CAMPUS	CAMPUS PHONE #
NAME OF SUPERVISOR	CAMPUS MAILING ADDRESS		CAMPUS PHONE #
PARENT OR GUARDIAN: NAME	ADDRESS		PHONE
PARENT OR GUARDIAN'S EMPLOYER	ADDRESS		MEDICAL INSURANCE CARRIER

DETAILS OF ACCIDENT / INCIDENT

INCIDENT DATE	TIME _____ A.M. _____ P.M.	LOCATION OF ACCIDENT	DATE REPORTED
DESCRIPTION OF WHAT HAPPENED			
REPORT WHAT YOU THINK CONTRIBUTED TO THE ACCIDENT			
TYPE OF INJURY (CUT, PUNCTURE, BURN, ETC.)		STATE BODY PART INJURED (LEFT OR RIGHT)	
WITNESS TO ACCIDENT/INCIDENT NAME: PHONE:	SIGNATURE OF INJURED/REPORTING PARTY	SIGNATURE OF SUPERVISOR DATE:	

MEDICAL REPORT

DIAGNOSIS & TREATMENT		
DISPOSITION ☐ COLLEGE NURSE ☐ PERSONAL PHYSICIAN ☐ RETURN TO WORK ☐ HOSPITAL ☐ HOME ☐ AMBULANCE ☐ REFUSE MED CARE	DATE	_____ A.M. _____ P.M.
PHYSICIAN ADDRESS		PHONE