

# Accident Report Form

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Name of Injured: \_\_\_\_\_ Age: \_\_\_\_\_

Address of Injured: \_\_\_\_\_

\_\_\_\_\_

Location of Accident: \_\_\_\_\_

Parent of Injured (if a minor): \_\_\_\_\_

Phone of Injured: \_\_\_\_\_

Name of person(s) who witnessed the accident:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Describe the accident and the action taken to address the injury:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For Office use only:**

**Rec'd by:** \_\_\_\_\_

**Date:** \_\_\_\_\_