

ARC  FLC   
SCC  DO   
CRC  FM   
College  
Center \_\_\_\_\_

LOS RIOS COMMUNITY COLLEGE DISTRICT

Report # \_\_\_\_\_

**STANDARD NON-EMPLOYEE ACCIDENT/INCIDENT REPORT FORM**

Date \_\_\_\_\_

**Confidential; Attorney Client Privileged; Attorney Work Product**

Report **ALL** accidents while on district properties or involved in district-sponsored activities.

**INSTRUCTIONS: PLEASE READ CAREFULLY AND FILL IN BLANKS COMPLETELY**

**IMPORTANT:** Completion of this form is for district records only. This is not a claim for benefits. The District does not carry insurance for students or non-employees. Describe the incident fully, with as much detail as possible.

**1** NAME: \_\_\_\_\_ Student I.D. Number: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Is injured person a student? Yes  No   
Sex: M \_\_\_\_\_ F \_\_\_\_\_ Telephone # \_\_\_\_\_ Age \_\_\_\_\_

**2** DATE of accident/incident: \_\_\_\_\_ TIME of accident/incident: \_\_\_\_\_

**3** LOCATION: \_\_\_\_\_ **4** ACTIVITY/CLASS: \_\_\_\_\_

NAME OF STAFF MEMBER in charge when accident/Incident occurred: \_\_\_\_\_

Present at scene of accident/incident? Yes  No

DESCRIPTION OF WHAT HAPPENED: What was the person doing? Where was the person? Specify any tool, machine, or equipment involved. \_\_\_\_\_

LIST names of other persons directly involved in the incident which resulted in the injury. (Attach separate sheet if additional space is required.) \_\_\_\_\_

<b>5</b> NATURE/TYPE OF INJURY: _____ Object or substance involved in the injury: _____	<b>6</b> PART OF BODY INJURED: _____ Did injury result in death? Yes <input type="checkbox"/> No <input type="checkbox"/>
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**7** Does injured person have medical insurance? Yes  No  If yes, what company? \_\_\_\_\_

**MEDICAL TREATMENT**

**8** IMMEDIATE ACTION TAKEN: By (Name): \_\_\_\_\_

Nature and extent of treatment: \_\_\_\_\_

Did injured person refuse medical treatment? Yes  No  Comments: \_\_\_\_\_

DISPOSITION: Injured Person Sent:  Home  Clinic  Hospital By: \_\_\_\_\_

INDIVIDUALS NOTIFIED:  Parent  Legal Guardian  Nearest Relative  Friend  Other: \_\_\_\_\_

Name of individual notified: \_\_\_\_\_ By(Name): \_\_\_\_\_

Witnesses: 1. Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Address: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Address: \_\_\_\_\_

**9** REMARKS: \_\_\_\_\_

**10** COLLEGE REMARKS: \_\_\_\_\_

**This form and the information contained in it is confidential and not a public record. The information is being collected in anticipation of potential litigation at the request of the Office of General Counsel.**

Printed name of person completing this report: \_\_\_\_\_

Signature of person completing report: \_\_\_\_\_

Signed-Loss Prevention Officer: \_\_\_\_\_