COASTAL BEND COLLEGE

Accident/Incident Report Alice-Beeville-Kingsville-Pleasanton

PLEASE COMPLETE THIS FORM WHEN INVOLVED IN A CAMPUS ACCIDENT AND RETURN TO THE SAFETY OFFICE IN THE ADMINISTRATION BUILDING WITHIN 24 HOURS.

Name:____________________ Address:____________________ __________________________ Home Phone:________________ Work Phone:________________	**Check One:** **Employee:** ف **Faculty** ف **Student** ف **Visitor** ف Contractor ف Other ف Student ID _________ or SS # ____________	**Did You Require:** **First Aid:** **Yes** ف **No** ف Medical Aid: Yes ف No ف Dr.________________ **Property Damage:** College: Yes ف No ف Personal: Yes ف No ف

Please be as specific as possible:

Date/Time of Accident: __________/___________ **Date Accident Reported:**______________

Location of Accident: (Building/Room Area/etc.)_ ____

Description of Accident: (include factors affecting accident: i.e. Water on floor, slippery, etc.)

____

____

____

Nature of Injury: (i.e. Cut finger, strain, bruise, etc.)

____

____

____

Do you have any suggestions for prevention of similar accidents: Yes ف No ف

If Yes, What?

____

____

Signature: ______________________________ Date: ___________

DO NOT WRITE BELOW THIS LINE:

Safety Officer: _______________________ Date: _______________________

Follow-up Date: __________________________ Action: (see attachment)

Thank you for your cooperation in completing this form promptly