Accident/Incident Report

(A copy of this report is not authorization for medical treatment.)

Instructions: For all claim types, complete sections 1 & 2.

• **For Workers' Compensation Claims:**	**Complete sections 3, 3A, 3B, 6, 7, and 8.**
• **For Accidents/Incidents Involving Students, Visitors, or Volunteers:**	**Complete sections 4, 6, 7, and 8.**
• **For Automobile or Property Claims:**	**Complete sections 5, 6, 7, and 8.**

Please Print: **Numerical Parish/School Code:**

1	School/Parish Name					
	School/Parish/Agency	☐ Workers' Compensation ☐ Student Accident ☐ Property Loss ☐ Automobile ☐ Visitor Accident/Incident		Person Injured: ☐ Employee ☐ Visitor ☐ Student ☐ Volunteer	Claim Report Number:	
2	Accident					
	Date of Loss (MM/DD/YYYY):	Time of Loss: _______ a.m. _______ p.m.		Location of Loss (Be specific):		
3	Employee (Workers' Compensation Claims)					
	Employee Name:			Date of Birth:	Injury Type (Cut, Bruise, etc.):	
	Occupation & Organization:			Part of Body Injured:		
	Home Address:	City:	State:	Zip:	Phone No.:	
	3A — Does Employee want medical attention today?: ☐ Yes ☐ No A "No" answer above does not waive the employee's right to request medical attention at a later date.	If "Yes", Designate referral: (Name of Physician, Clinic, Hospital)		**3B** — Will Employee require time off from work?: ☐ Yes ☐ No	Expected Return to Work Date:	
4	Claimant (Student, Visitor, or Volunteer Involved in the Accident/Incident)					
	Name:			Date of Birth:	Time Injury First Reported:	
	Address:	City:	State:	ZIP:	Phone No.:	
5	Property (Church-Owned) Attach picture of damaged or stolen property, Police and/or Public Safety report					
	Describe damaged or stolen property:					
	Estimated cost of damage or value of stolen item:					

6	**Witness(es)**				
	Name:				
	Address:	City:	State:	Zip:	Phone No.:
	Name:				
	Address:	City:	State:	Zip:	Phone No.:
7	**Describe the Accident/Incident/Loss** (To be completed by the Employee, Student, Visitor, Volunteer, or Entity Representative. If the Employee, Student, Visitor, or Volunteer is unable to write, the Entity Representative will ask the following questions and write the responses.)				
A.	What were you doing (or what was happening) when the injury/loss occurred?				
B.	How did the injury/loss occur?				
C.	In your opinion, which object or substance directly caused your injury (or caused the loss)?				
D.	Was training received? If applicable, was personal protective equipment (PPE) being worn?				
E.	What could have been done (and when) to prevent the injury or loss?				
F.	What corrective actions have been taken? What lessons were learned? What additional actions should be taken?				
8	**Signatures**				
	Signature of Employee/Claimant:				Date:
	Signature of Entity Representative:				Date:

Send a copy of the completed form to Tom Martin (martint@ptdiocese.org) as soon as possible.