PUBLIC INJURY REPORT

This report must be completed and sent to the Risk Management Department within 24 hours of notification of incident.(Fax: 215-2181)

INJURY INFORMATION

(Please Print)

Employee Reporting Incident: ______________________Department: ______________Phone #___________

Address/Location/Facility _______ ____

Date of Incident: _____/_____/_____ Time: ___________ am/pm (circle) Date Reported: _____/_____/_____

Name of Injured Person: ________________________________ Phone # ______________________________

Address: ____City/State/Zip _____________________________

Date of Birth: ____/____/____ Sex ____M ____ F If minor, were parent contacted? ____Yes ____ No

If not, Why? ____

____

Describe Injuries: ____

____

Describe <u>in detail</u> the sequence of events that directly caused the incident: ______________________________

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Contributing Factors: ____

Other Parties Involved: (Include name and number):____

____

Witnesses to Accident (Include name and number): ____

____

Describe any staff action taken: ____

____

Type of Treatment: o First Aid o Rescue o 911 Called o Refused Treatment o Other ________________

Signature: ____ Date: ___________________