

# Accident Report Form

Date: \_\_\_\_\_ Time of Injury: \_\_\_\_\_ am/pm Time Notified: \_\_\_\_\_ am/pm  
 Injured Person's Name: \_\_\_\_\_ 92#: \_\_\_\_\_  M  F D.O.B.: \_\_\_/\_\_\_/\_\_\_  
 Local Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Status:  Student  Faculty  Staff  Other: \_\_\_\_\_ Injured Person's Signature: \_\_\_\_\_

**Location of Accident**

**Indoor Facilities**

CRC:  Gyms  Track  Fitness Floor  Climbing Wall  Studio 1 or 2, specify: \_\_\_\_\_  Other: \_\_\_\_\_

Reid:  Pool  1<sup>st</sup> Floor Gyms  2<sup>nd</sup> Floor Gyms

**Outdoor Facilities**

Bermuda Field  Camp Lab Fields  WCU Stadium  Norton Field  Band Practice Field  Other: \_\_\_\_\_

**Program Area:**

Informal Rec  Intramurals  Clubs  Group X  Personal Training  Special Event  Other: \_\_\_\_\_

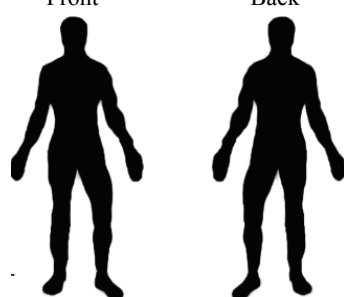
Description of Accident: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\*Continue on back if needed

Body Fluid Spill:  YES – See back side  NO Was 911 Called:  YES – See back side  NO

**Action Taken by CRW Employee**

Administered CPR  Administered AED  First Aid Care:  Ice  Bandage(s)  Athletic Tape  Splint  Other: \_\_\_\_\_  
 Additional Care: \_\_\_\_\_

Possible Nature of Injury	Check Part of Body Injured		Put an "X" on Injured Area	
		L R	L R	Front Back
<input type="checkbox"/> Bruise	<input type="checkbox"/> Head	<input type="checkbox"/> <input type="checkbox"/> Hand	<input type="checkbox"/> <input type="checkbox"/> Foot	
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Face	<input type="checkbox"/> <input type="checkbox"/> Wrist	<input type="checkbox"/> <input type="checkbox"/> Ankle	
<input type="checkbox"/> Fracture	<input type="checkbox"/> Neck	<input type="checkbox"/> <input type="checkbox"/> Forearm	<input type="checkbox"/> <input type="checkbox"/> Shin	
<input type="checkbox"/> Cut	<input type="checkbox"/> Chest	<input type="checkbox"/> <input type="checkbox"/> Elbow	<input type="checkbox"/> <input type="checkbox"/> Knee	
<input type="checkbox"/> Sprain	<input type="checkbox"/> Back	<input type="checkbox"/> <input type="checkbox"/> Upper Arm	<input type="checkbox"/> <input type="checkbox"/> Hamstring	
<input type="checkbox"/> Strain	<input type="checkbox"/> Finger	<input type="checkbox"/> <input type="checkbox"/> Shoulder	<input type="checkbox"/> <input type="checkbox"/> Quadricep	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Abdomen	<input type="checkbox"/> <input type="checkbox"/> Ribs	<input type="checkbox"/> <input type="checkbox"/> Groin	
	<input type="checkbox"/> Toe	<input type="checkbox"/> <input type="checkbox"/> Pelvis	<input type="checkbox"/> <input type="checkbox"/> Other: _____	

Transported by (person): \_\_\_\_\_ Transportation Method (walk, car, ambulance): \_\_\_\_\_  
 First Responder: \_\_\_\_\_ Secondary Responder(s): \_\_\_\_\_  
 Submitted by: \_\_\_\_\_ Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Release Signature:** *Refusing Attention* – I have been advised that I may have a medical condition(s) which may require examination by a medical professional and I refuse such advice and/or medical -OR- I do not believe a medical emergency exists and I require no further assistance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

Witness Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Description of Accident: \_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Description of Accident Continued: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

REMEMBER TO DO THE FOLLOWING EVERY TIME YOU HAVE AN EMERGENCY SITUATION:

1. Activate the emergency action plan/Call 911.
2. Protect the individual from further injury.
3. Maintain life or attempt to restore life.
4. Comfort and reassure the individual.

COMPLETE AN ACCIDENT REPORT FOR EVERY ACCIDENT.

WHEN ACTIVATING 911 FOR HELP REMEMBER TO GIVE THE FOLLOWING INFORMATION:

1. The EXACT location.
2. What has happened.
3. Number of victims.
4. The telephone number from which you are calling.

CALL FOR AN AMBULANCE WHEN THE VICTIM REQUESTS ONE, THE POLICE REQUEST ONE, OR IN A SITUATION WHERE IT IS OBVIOUS THAT AN AMBULANCE IS NEEDED.

ALWAYS GET A WITNESS TO SIGN THE ACCIDENT REPORT FORM.

911 RESPONSE DOCUMENTATION

Time 911 Call Was Placed: \_\_\_\_\_ am/pm

Time Police Arrived (if applicable): \_\_\_\_\_ am/pm

Time Ambulance Arrived: \_\_\_\_\_ am/pm

Time Ambulance Departed Facility: \_\_\_\_\_ am/pm

Did participant leave with ambulance?  Yes  No

Person Who Placed The Call: \_\_\_\_\_ Status:  CRW Staff  Student  Faculty  Staff  Public

Address: \_\_\_\_\_

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

BODY FLUID SPILL CHECKLIST

If the accident involved a body fluid spill, do the following:

- Wear gloves while handling any bodily fluid spills!
- Use a face mask when administering CPR.
- Clean up the area using Precise and a rag/paper towel.
- Dispose of the contaminated supplies (gauze, gloves, paper towels, etc...) using the biohazard bags into the biohazard bin.
- Thoroughly wash hands after the incident.
- If you believe you were exposed to body fluids during this situation, contact your supervisor immediately.