



VISITOR ACCIDENT/INJURY REPORT

Name of Injured: _____ Date: _____

Building/Facility: _____ Time of Incident: _____

Purpose of Visit: _____

Supervised Activity: YES NO If yes, name of supervisor: _____
(please circle one)

Description of injury/accident: (indicate part of body injured, visible symptoms and complaints of injured party)

Description of incident:

Name of witnesses if applicable: _____

Action Taken

1. Was first aid given? YES NO By Whom: _____
(please circle one)

Describe: _____

2. Was family member notified? YES NO By Whom: _____
(please circle one)

3. 911 notified (police or medic)? YES NO By Whom: _____
(please circle one)

Results: _____

4. Other Action: _____

Completed by: _____ Date _____

Signature: _____
District Employee Title

A copy of this report is to be filed with the Director of Business Affairs

Signature: _____ Date _____
Director of Business Affairs