

**ACCIDENT REPORT
UNIVERSITY OF LA VERNE**

Date of Accident: _____ Time: _____

Location of Accident: _____

Description of Accident:

Name of Individual Involved in Accident: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone No: Residence : (____) _____ Work/Message: (____) _____

Witnesses:

Name: _____ Name: _____

Address: _____ Address: _____

Telephone: (____) _____ Telephone: (____) _____

Medical Attention Received/Description of Injury: _____

Paramedics Called: Yes: _____ No: _____

If answer is yes, where taken:

Taken to Hospital: Yes: _____ No: _____

Report Completed By: _____ Date of Report: _____

Page 2/Accident Report

Position/Title: _____

Follow Up Action Taken By ULV;

Date of Contact by ULV Health Center: _____

Comments Regarding Contact:

If A Follow Op Is Necessary Please Indicate Below:

Suggested Measures to be Taken to Avoid Another Similar Accident:

Report Completed by: _____ Date of Report: _____

Position/Title: _____