Student Accident Report

TEXAS CHRISTIAN UNIVERSITY

Return form to:

Risk Management
Box 297110, Secrest-Wible Bdlg
817-257-7778

STUDENT CONTACT INFORMATION

Name: _____ Daytime phone: _____

Address: _____ Evening phone: _____

City/State: _____ Age: _____ Sex: _____ SSN or TCU ID number: _____

***Please complete if the student is a paid employee*:**
Is the student a paid employee of the university: ___ yes ___ no Was the student injured performing job duties: __ yes __ no

ACCIDENT INFORMATION

Date of Accident: _____ Time of Accident: _____ a.m. p.m. Date of Report: _____

Describe the Accident: _____

_____

_____

_____

_____

Location of the Accident: _____

_____

Describe the Injury: _____

_____

_____

Describe any Property Loss: _____

_____

_____

TRANSPORTATION INFORMATION

Check all that apply:

None Provided: _____ Transported by Ambulance: _____
Taken to Health Center: _____ Driven by friend/Individual: _____
Taken to Hospital: _____ Transported by Campus Police: _____

If applicable:

Treatment Refused: ____yes ____no Name of Hospital: _____ Treating Physician: _____

WITNESS INFORMATION

Name/Address: _____ Daytime phone: _____

Name/Address: _____ Daytime phone: _____

Name/Address: _____ Daytime phone: _____

Name/Address: _____ Daytime phone: _____

Completed by: _____ Date: _____