Accident Report Form

Parkway United Methodist Church

To be completed and turned into Ministry Staff Leader or Facility Coordinator within 12 hours of incident/accident

Incident Date: _____Incident Time: _____

Injured Persons Name: _____

Address: _____

Phone Number(s): _____

Male/Female: _____ Date of Birth: _____

Name of event Injured Person attending: _____

Details of Incident:

_____

_____

_____

Injury Type: _____

Does Injury require Hospital/Dr. visit?: _____

Was ambulance called?: _____

Hospital Name:_____

Address: _____

Other people present: _____

For Office Use Only

Date Received_____ Approved by:_____