



# Student Accident Report

TEXAS CHRISTIAN UNIVERSITY

Return form to:

Risk Management  
Box 297110, Secrest-Wible Bldg  
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: \_\_\_\_\_  
Taken to Health Center: \_\_\_\_\_  
Taken to Hospital: \_\_\_\_\_

Transported by Ambulance: \_\_\_\_\_  
Driven by friend/Individual: \_\_\_\_\_  
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: \_\_\_\_\_