



# Visitor Accident Report

TEXAS CHRISTIAN UNIVERSITY  
Return form to:

TCU Risk Management, Box 297110  
Fort Worth, Texas 76129  
817-257-7778

## VISITOR CONTACT INFORMATION

Name: \_\_\_\_\_ Daytime phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Evening phone: \_\_\_\_\_  
City/State: \_\_\_\_\_ Cellular phone: \_\_\_\_\_

## 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### *If applicable:*

Vehicle Make/Model: \_\_\_\_\_ State/License Plate Number: \_\_\_\_\_

Was the visitor a participant in a conference:  yes  no Name of conference: \_\_\_\_\_

## MEDICAL/TRANSPORTATION INFORMATION

None Provided (✓): \_\_\_\_\_ Transported by Ambulance (✓): \_\_\_\_\_  
Taken to Hospital/clinic (✓): \_\_\_\_\_ Driven by friend/Individual (✓): \_\_\_\_\_  
Hospital/clinic name: \_\_\_\_\_ Treating Physician: \_\_\_\_\_

## WITNESS INFORMATION

Name/Address: \_\_\_\_\_ Daytime phone: \_\_\_\_\_  
Name/Address: \_\_\_\_\_ Daytime phone: \_\_\_\_\_  
Name/Address: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_