Visitor Accident Report

TEXAS CHRISTIAN UNIVERSITY
Return form to:

TCU Risk Management, Box 297110
Fort Worth, Texas 76129
817-257-7475

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: _____