Accident/Incident Report Form

Date of incident: _____ Time: _____ AM/PM

Name of injured person: _____

Contact information of injured person:

Address: _____

Phone Number(s): _____

E-mail: _____

Date of birth: _____ Male ☐ Female ☐

Place where incident took place: _____

_____

Type of injury: _____

Details of incident: _____

_____

_____

_____

_____

Details of injury/incident response/treatment: _____

_____

_____

_____

_____

Injury/incident requires physician/hospital visit? Yes ☐ No ☐

Name of physician/hospital: _____

Address: _____

Phone number of physician/hospital: _____

_____

Name and signature of witness Date

Name and contact information for nearest InFaith Field Staff: _____

_____

_____

Signature of injured party Date

Return this form to bmackey@infaith.org within 24 hours of incident.