UNIVERSITY OF NEW ORLEANS

Loss Claims Office

Accident Report - Non-employees

(Fill out form & return within 24 hrs. to: Sherri Ganucheau; Risk Management Coordinator, Computer Center, Room 223 - C, Extension: 6768

DATE: ________________________________ TIME: ___________________________

LOCATION (Bldg./Area) ____

INFORMATION ON ACCIDENT VICTIM:
NAME:
____

ADDRESS:
____
CITY STATE ZIP

TELEPHONE: _____________________ AGE: ___________ SOCIAL SECURITY #: ______________________

WITNESSES:
NAME TELEPHONE NUMBER
____
____

TYPE OF INJURY:

____ Abrasion ____ Cramps ____ Internal ____ Shock
____ Bruise ____ Dislocation ____ Laceration ____ Sprain
____ Concussion ____ Fracture ____ Scratch ____ Strain
____ Other: ____

BODY PART INJURED:

____ Generalized ____ Neck ____ Shoulder ____ Hip ____ Right
____ Skull/Scalp ____ Spine ____ Upper arm ____ Thigh
____ Eye ____ Chest ____ Elbow ____ Knee ____ Left
____ Ear ____ Lungs ____ Forearm ____ Lower leg
____ Nose ____ Abdomen ____ Wrist ____ Ankle
____ Mouth ____ Back ____ Hand ____ Foot
____ Tooth ____ Pelvis ____ Finger ____ Toe
____ Jaw ____ Other: ____

BRIEF DESCRIPTION OF ACCIDENT: ____
____
____
____
____

IMMEDIATE ACTION TAKEN:
____
____

REPORT COMPLETED BY: ____
Print & Sign Date

REPORT REVIEWED BY: ____
Print & Sign Date

Position: ____