

NORTH COAST SECTION, CIF
5 Crow Canyon Court, Suite 209
San Ramon, CA 94583
Phone: 925-263-2110 Fax: 925-263-2120

ACCIDENT REPORT

TO BE COMPLETED IMMEDIATELY!

The person who either witnesses the accident or is conducting the activity at the time of the accident, should complete this form, if possible. The report should be submitted immediately to the NCS Commissioner's Office. Should other pertinent facts develop, notify the NCS Office. This report is for the confidential use of NCS staff and NCS/CIF legal counsel, and may be used in defending litigation.

NAME OF NCS EVENT _____ **LOCATION** _____

ADDRESS _____ **PHONE NUMBER** _____

NAME _____ **PARENT/GUARDIAN NAME (if minor)** _____ **DATE OF BIRTH** _____ **SEX** _____ **GRADE** _____

HOME ADDRESS _____ **PHONE NUMBER** _____

WHERE DID ACCIDENT OCCUR? _____ **DATE OF INCIDENT** _____ **TIME OF INCIDENT** _____

DESCRIPTION OF ACCIDENT _____

NATURE OF INJURY _____ **PART OF BODY INJURED** _____

<p>Abrasion _____ Burn _____ Fracture _____</p> <p>Asphyxiation _____ Concussion _____ Poisoning _____</p> <p>Bite _____ Cuts _____ Puncture _____</p> <p>Bruise _____ Dislocation _____ Sprain _____</p> <p>Other (specify) _____</p>	<p>Abdomen _____ Ear _____ Foot _____ Mouth _____</p> <p>Ankle _____ Elbow _____ Hand _____ Nose _____</p> <p>Arm _____ Eye _____ Head _____ Scalp _____</p> <p>Back _____ Face _____ Knee _____ Tooth _____</p> <p>Chest _____ Finger _____ Leg _____ Wrist _____</p> <p>Other (specify) _____</p>
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FIRST AID APPLIED _____ **BY WHOM?** _____ **DISPOSITION OF INJURED PERSON (Return to class, home, doctor, hospital)** _____

Yes No

DOES INJURED PERSON HAVE ACCIDENT INSURANCE COVERAGE? _____ **NAME OF INSURANCE COMPANY** _____

Yes No

WAS THE INJURED PERSON ACTING IN A RESPONSIBLE MANNER? _____ **IF SO, EXPLAIN** _____

Yes No

WITNESSES PRESENT AT TIME OF ACCIDENT

NAME _____	ADDRESS, CITY, ZIP _____	PHONE NUMBER _____
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WAS INJURED PERSON TOLD HE/SHE WILL BE CONTACTED AGAIN? EXPLAIN BELOW Yes No

COMMENTS

REPORT SUBMITTED BY _____	POSITION _____	DATE _____	REPORTING PERSON'S SIGNATURE _____	DATE _____
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PLEASE RETURN THIS FORM TO THE NCS OFFICE AS SOON AS POSSIBLE. YOUR COOPERATION IS VERY MUCH APPRECIATED.

Rev 10/7