

NORTH ORANGE COUNTY COMMUNITY COLLEGE DISTRICT STUDENT ACCIDENT/ILLNESS REPORT

Mark ALL that apply

Anaheim Campus
 Cypress College
 Fullerton College
 NOCE CC Wilshire

CONFIDENTIAL-ATTORNEY/CLIENT WORK PRODUCT PRIVILEGE

This report is to be completed by District employees. This form is a confidential, internal, document: its contents are not to be shared or copied for any persons who are not District employees and/or their legal representatives.

IN CASE OF SERIOUS INJURIES A TELEPHONE REPORT IS TO BE MADE IMMEDIATELY MAR

NOTE: The District employee either witnessing the ACCIDENT/INCIDENT or supervising at the time should complete and **submit this form within 24 hours.** Please type or print using ball-point pen.

DATE OF ACCIDENT/INCIDENT		TIME OF ACCIDENT/INCIDENT <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		DATE OF REPORT		TIME OF REPORT <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
NAME OF INJURED PERSON (LAST, FIRST, M.I.)				DATE OF BIRTH		TELEPHONE NUMBER OF INJURED PERSON	
ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE, AND ZIP CODE)							
SITE OF ACCIDENT/INCIDENT				ACTIVITY ENGAGED IN (If in class, Course #, Title, etc)			
DESCRIBE HOW THE ACCIDENT/INCIDENT OCCURRED – TO BE COMPLETED BY INJURED PERSON IF POSSIBLE (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)							
				SIGNATURE – INJURED PERSON		DATE	
PERSON IN CHARGE AT TIME OF ACCIDENT/INCIDENT		TITLE		ACCIDENT/ INJURY REPORTED TO PERSON IN CHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO		WAS HE/SHE PRESENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
INJURED VIOLATED SCHOOL RULE <input type="checkbox"/> YES <input type="checkbox"/> NO							
COMMENTS – PERSON IN CHARGE (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)							
				SIGNATURE – PERSON IN CHARGE		DATE	
NAME OF WITNESS(ES)		ADDRESS		TELEPHONE NO.		STATUS (Student, Volunteer, etc.)	
				()			
				()			
APPARENT NATURE OF INJURY (PLEASE CIRCLE)				INJURED PART OF BODY (PLEASE CIRCLE) <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT			
Abrasion Bruise Fracture Strain/Sprain Contusion Laceration Dislocation Internal Concussion Foreign Body Burn Puncture Wound Other (explain) _____				Head, Eye, Nose, Mouth, Teeth; Neck; Shoulder: Back; Collar Bone; Upper Arm; Lower Arm; Wrist; Hand; Fingers Thumb, 2, 3, 4, 5; Ribs; Abdomen; Upper Leg; Knee; Lower Leg; Ankle; Heel; Foot; Toes Large Toe, 2, 3, 4, 5; Other (explain) _____			
DESCRIPTION OF CARE PROVIDED							
NAME AND TITLE OF PERSON WHO ADMINISTERED CARE				DISPOSITION OF INJURED AFTER ACCIDENT/INCIDENT OR CLASS <input type="checkbox"/> Home <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital			
INSURANCE: <input type="checkbox"/> Private <input type="checkbox"/> No Insurance		SCHOOL INSURANCE FORM GIVEN <input type="checkbox"/> YES <input type="checkbox"/> NO If No, Reason					
NAME OF PERSON COMPLETING REPORT		TITLE		DEPARTMENT		TELEPHONE NUMBER ()	
PERSON WAS AN EYE WITNESS <input type="checkbox"/> YES <input type="checkbox"/> NO		SIGNATURE OF PERSON COMPLETING REPORT				DATE SIGNED	

For your protection California law requires the following to appear on this form. "It is unlawful to: (a) present or cause to be presented any false or fraudulent claim for payment of a loss under a contract of insurance; (b) prepare, make or subscribe any writing with intent to present or use the same, or allow it to be presented or used in support of such claim. Every person who violates any provision of this section is punishable by imprisonment in the State Prison not exceeding 3 years or by fine not exceeding \$1,000 or by both."

Distribution List: District Risk Management
 Campus Administrator (To be forwarded to Admin. or Facilities Office)
 Health Service
 Department