

DIOCESE OF YAKIMA ACCIDENT REPORT

(For Non-Employees)

* = Required Field

MEMBER NAME

* PARISH/SCHOOL

* ADDRESS

* CITY * ZIP

* PHONE NUMBER PARISH EMAIL

* PERSON REPORTING

DATE FORM COMPLETED (MM/DD/YYYY)

* DATE OF ACCIDENT (MM/DD/YYYY) TIME OF ACCIDENT (10:00 A.M.)

WHERE ACCIDENT OCCURRED

WERE PHOTOGRAPHS TAKEN?

DESCRIBE ACCIDENT

PARTY INVOLVED-NAME STUDENT?

IF STUDENT, PARENT NAME(S)

ADDRESS

CITY ZIP

PHONE NUMBER WORK NUMBER

DOB (MM/DD/YYYY) SS#

INJURY/DAMAGE

TRANSPORTED BY AMBULANCE?

WITNESSES (PLEASE INCLUDE ADDRESS AND PHONE NUMBER)

COMMENTS

Completed form should be submitted to Catholic Mutual via email to Reportclaim@catholicmutual.org
Copy should also be sent to sue.schoolcraft@yakimadiocese.org
Keep a copy for your records.

CARES

RISK MANAGEMENT INFORMATION *Catholic Mutual . . . "CARES"*

ACCIDENT INVESTIGATION REPORT

I. Identification of the Accident:

Name of Injured: _____ Date of Accident: _____

Time of Accident: _____ Location of Accident: _____

II. Nature of Injury:

Exact part of body affected and type of injury: _____

Description of HOW and WHY accident occurred:

Names of witnesses: _____

III. Accident Prevention Information:

Equipment, tool, or item causing injury: _____

Was accident caused by failure to use or observe safety practices, policies, or regulations? _____

IV. Corrective Action:

What corrective action can be done to prevent a recurrence of this accident/injury?

Comments/Recommendations (by Safety Committee, Safety Director, or Supervisor):

Person(s) responsible for corrective action: _____

Safety Director/Manager Review: _____

Signed

Date

(Revised 10/05)

