

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

INSTRUCTIONS

- **SEND COMPLETED FORM TO REPORTACCLAIM@CATHOLICMUTUAL.ORG OR FAX TO 402-551-2943.**