Orange County Office for the Aging

Accident Report

Name: _____

Address: _____

Phone #: _____Date of Birth: _____

Sex: M or F (Please check one)

Insured is: (check one)
Community Site Vol _____HDM Vol _____RSVP Vol_____

Staff _____Other_____

Date of Accident: _____Time of Accident: _____am _____pm

Description of Accident: _____

_____

_____

_____

Nature of Injury and Part(s) of Body Affected: _____

_____

_____

Did you seek Medical care? _____YES _____NO If yes, when? _____

_____

Name and Address of Doctor or Hospital: _____

_____

_____

What was person doing when injured: _____

_____

_____

_____

Over

How did the accident or exposure occur: _____

_____

_____

Verbally Reported Accident to: _____ Date: _____

Date of Report: _____Submitted by: _____

Injured Signature: _____

Reported by: _____

Witness Name: _____

Witness Address: _____

_____

Witness Statement: _____

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