ACCIDENT REPORT

* = Required Field

(For Non-Employees)

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

SEND COMPLETED FORM TO REPORTACLAIM@CATHOLICMUTUAL.ORG OR FAX TO 402-551-2943. REPORTACLAIM PH# 800-228-6108 X2444