



Accident Form

Name of Injured person: _____

Address: _____ ZIP: _____

Phone: _____ Sex: _____ Age: _____

Date: _____ Time of Accident: _____

Place of Accident: _____

What was the person doing at the time of accident?

How did the injury occur?

What caused the injury?

Describe in detail the injury and indicate the part of the body that was affected?

Describe the treatment of the accident?

Name and address of physician/hospital:

Name(s) and address(es) of witness(es):

1. _____

2. _____

3. _____

Describe any act or condition, which may have contributed to the accident.

What corrective action could be taken to eliminate the problem from re-occurring?

Signed: _____ Date: _____

This report must be sent to the OSSO Registrar within 24 hours of accident.