



## Volunteer Accident Report

Volunteers are required to complete this form with their program liaison or coordinator when they have an accident while volunteering. **This form must be completed within 24 hours of the incident.** If you are unable to complete this form within 24 hours, your liaison or coordinator is required to complete the form by telephone. Report form should be sent to the Manager of Volunteer Services within 48 hours of incident.

### Volunteer information

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

### Incident Information

Date of Incident: \_\_\_\_\_ Date Volunteer Services notified: \_\_\_\_\_

#### Type of Occurrence & Description:

\_\_\_\_\_ Auto Accident      \_\_\_\_\_ Exposure (Chemical/Blood borne Pathogen)

\_\_\_\_\_ Fall      \_\_\_\_\_ Other (describe) \_\_\_\_\_

\_\_\_\_\_ Back Injury      \_\_\_\_\_ Other Accident: \_\_\_\_\_

Location of Occurrence & Address: \_\_\_\_\_

Witness to Occurrence: \_\_\_\_\_ Phone #: \_\_\_\_\_

#### Description of Occurrence & Contributing Factors:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

No treatment  Treated and returned to service  Treated and sent home

Name of Volunteer's Physician: \_\_\_\_\_ Follow-Up Required: Yes  No

Report Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Follow-up by Manager of Volunteer Services: \_\_\_\_\_ Initials: \_\_\_\_\_