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INSURANCE DEPARTMENT
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LOS ANGELES, CA 90010-2241

Archdiocese of Los Angeles
Incident/Accident Report
(Non-Automobile) – Form #A.8 (Rev. 1-00)

CONFIDENTIAL-ATTORNEY/CLIENT WORK PRODUCT PRIVILEGE
This report is to be completed by employees of the Archdiocese of Los Angeles or any of its constituent organizations. This form is a confidential, internal document: its content are not to be shared or copied for any persons who are not employees and/or their legal representatives.
IN CASE OF SERIOUS INJURIES A TELEPHONE REPORT (213 / 637-7663) IS TO BE MADE IMMEDIATELY.

DATE OF REPORT	NOTE (1): Please do not use this report if injured person is an employee. NOTE (2): The employee either witnessing the accident or supervising at the time, should complete and submit this form within 24 hours. Please type or print using ballpoint pen.

NAME OF INJURED (LAST, FIRST, M.I.)	AGE	GRADE (if applicable)	TELEPHONE NUMBER OF INJURED PERSON ( )

IS INJURED PERSON A MINOR? ☐ YES ☐ NO ➔	NAME OF PARENT OR LEGAL GUARDIAN

ADDRESS OF PERSON INJURED (NUMBER, STREET, APT#, CITY, STATE, ZIP CODE)
2.

WHERE DID ACCIDENT OCCUR? (Be specific, e.g. front steps, gym, student parking lot, etc…) 3.	DATE (MONTH, DAY, YEAR)	TIME ☐ A.M. ☐ P.M.

DESCRIBE HOW ACCIDENT OCCURRED (USE FACTS ONLY, EXCLUDE OPINIONS AND/OR ASSUMPTIONS). IF NECESSARY, USE ADDITIONAL SHEET(S).
4.

NAME (FIRST AND LAST) OF PERSON IN CHARGE AT TIME OF ACCIDENT 5.	TITLE	WAS HE/SHE PRESENT AT THE TIME? ☐ YES ☐ NO	INJURED PERSON VIOLATE ANY RULES? ☐ YES ☐ NO

6. NAME OF WITNESS(ES)	ADDRESS	TELPHONE NO.	STATUS

NAME OF PARISH, SCHOOL, OFFICE, CEMETERY, ETC.
7.

ADDRESS (NUMBER, STREET, CITY, ZIP CODE)	TELEPHONE NO. ( )

8. APPARENT NATURE OF INJURY (PLEASE CHECK)	9. INJURED PART OF BODY (PLEASE CHECK)
☐ Abrasion ☐ Fracture ☐ Strain/Sprain ☐ Contusion ☐ Cut ☐ Dislocation ☐ Internal ☐ Concussion ☐ Other (explain)_____	☐ Head ☐ Finger ☐ Arm ☐ Abdomen ☐ Neck ☐ Eye ☐ Leg ☐ Hand ☐ Back ☐ Chest ☐ Face ☐ Foot ☐ Other (explain) _____

FIRST AID PROCEDURES USED 10.	NAME OF PERSON WHO ADMINISTERED FIRST AID

DISPOSITION OF INJURED AFTER ACCIDENT OR CLASS 11. ☐ Home ☐ Doctor ☐ Hospital	WHO WAS NOTIFIED 12.	RELATIONSHIP TO INJURED

IF INJURED PERSON LEFT PREMISES, TO WHOM RELEASED 13.	NAME AND ATTITUDE OF ANYONE CONTACTING LOCATION 14.

15. MEDICAL BENEFITS AVAILABLE? ☐ YES ☐ NO	NAME OR COMPANY	REMARKS 16.

REMARKS CONTINUED

For your protection California law requires the following to appear on this form. "Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

NAME OF PERSON COMPLETING REPORT 17.	STATUS	TELEPHONE NUMBER OF PERSON ( )

ADDRESS OF PERSON (NUMBER, STREET, CITY, STATE, ZIP CODE)	WAS PERSON AN EYE WITNESS ☐ YES ☐ NO

SIGNATURE OF PERSON APPROVING REPORT	DATE SIGNED

Continue on reverse side or next page

CONFIDENTIAL INCIDENT/ACCIDENT REPORT
EQUIPMENT REPORT
(MUST COMPLETE IF EQUIPMENT ALLEGEDLY CAUSED INJURY OR PROPERTY DAMAGE)

USE BLANK SHEET IF NECESSARY

Equipment involved (DESCRIBE): _____

Brand Name _____ Model or style number _____

Color _____ Size _____

Date Purchased _____ Where? _____

Manufacturer _____ Address _____

Condition of equipment: New _____ Used _____ Repaired _____

Approximate date of last service _____

Who has equipment? (NOTE: IF POSSIBLE TRY TO RETAIN THE EQUIPMENT) _____

Describe nature of injury or damage _____

_____

How did it occur? _____

_____

Comments: _____

_____

Name of person taking report _____

EMPLOYEE'S REPORT

Name (Print) _____

How soon after incident did you inspect location? _____ Location clean? ☐ YES ☐ NO

Dry? ☐ YES ☐ NO Any puddles? ☐ YES ☐ NO Describe lighting _____

Describe location or condition _____

_____

Does injured person wear glasses? ☐ YES ☐ NO Type and condition of shoes _____ Any bundles? ☐YES ☐NO

Where were you when the incident occurred? _____

Did you see the incident? ☐ YES ☐ NO If so, describe fully _____

_____

_____

Injured person's comments and attitude (IF QUESTION NOT APPLICABLE, ANSWER N/A) _____

_____

Signature _____

HOUSEKEEPING/MAINTENANCE REPORT

(TO BE COMPLETED IF INJURED PERSON SLIPPED OR FELL OR IF INCIDENT INVOLVED AN ELEVATOR)

Name (PRINT) _____

Are you responsible for maintaining incident location? ☐ YES ☐ NO If not, who is? _____

If so, describe your time schedule for cleaning location _____ Last time cleaned _____

Time last dressed _____ Floor product used _____

When, before incident, did you last inspect location? _____

Describe its condition _____

Was location clean? ☐ YES ☐ NO Dry? ☐ YES ☐ NO Lighting? ☐ YES ☐ NO

If elevator involved, specify exact one involved _____

Remarks: _____

_____