



Eastern Kentucky University

Serving Kentuckians Since 1906

VISITOR ACCIDENT REPORT FORM

I. Individual Involved In Accident

Name: _____
Last First M.I.

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Phone #: _____ Sex: Male / Female Age: _____

II. Accident Details

Date of Accident: _____ Time of Day: _____

Exact Location of Accident: _____

Details of Accident: _____
(What, How, Why)

(Use Separate Sheet If Necessary)

Estimated Severity of Accident: Non-Disabling (Loss of Less Than a Full Day of Normal Activity)
(Check One) Disabling (Loss of One or More Days of Normal Activity)
 Fatal

Details of Injury: _____

Property Damage? Yes/ No If Yes, Estimated Cost: \$ _____
(Circle One)

Witness(es): _____
Name Phone Number

Name (Continue on Reverse Side) Phone Number





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III. Follow Up

Emergency Care Provided: First Aide Rendered, No Hospital or Emergency Services Required
(Check one) First Aide Rendered, Emergency Services Only

First Aide Rendered, Emergency Services And/ Or Hospital Services
 Admission to Hospital Duration of Stay: _____

None
 Other: (Specify) _____

What Could Have Prevented This Accident: _____

What Actions Have Occurred For Preventing Similar Accidents: _____

Has This Been Effective: Yes/ No
(Circle One)

Explain: _____

Report Prepared By: _____

Name

Title

Preparer's Address: _____

Phone: _____

Date Report Filled Out: _____

Return Form To:

EKU Claims Specialist
Office of Risk Management
Million House
521 Lancaster Avenue
Richmond, KY 40475-3102

Phone: (859) 622-5523
Fax: (859) 622-1258

IV. Official Office Use Only

Report Received By: _____

Name

Date Received: _____

Time Received: _____

Date Processed: _____

Date Filed: _____

