ACCIDENT REPORT

(For Non-Employees)

* = Required Field

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 (10:00A.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/YY) SS#

INJURY/DAMAGE

TRANSPORTED BY AMBULENCE

WITNESSES (PLEASE INCLUDE ADDRESS AND PHONE NUMBER)

COMMENTS

VOLUNTEER REPORT ONLY

MINISTRY

ONCE FORM IS COMPLETED:

- ***EMAIL COMPLETED FORM TO CATHOLIC MUTUAL GROUP AT REPORTACLAIM@CATHOLICMUTUAL.ORG***
  - ***INCLUDE ANY PICTURES OF THE ACCIDENT AREA AND DAMAGE OCCURRED WHEN SUBMITTING FORM.***
- ***NOTIFY THE DOSP INSURANCE & RISK MANAGEMENT OFFICE BY EMAILING FORM TO VCB@DOSP.ORG OR FAX 727-374-0214***
- ***ALL CLAIMS SHOULD BE REPORTED WITHIN 48 HOURS OF OCCURRENCE.***