Visitor Accident Report

TEXAS CHRISTIAN UNIVERSITY
Return form to:

TCU Risk Management, Box 297110
Fort Worth, Texas 76129
817-257-7778

VISITOR CONTACT INFORMATION

Name: ____________________ Daytime phone: ____________

Address: ____________________ Evening phone: ____________

City/State: ____________________ Cellular phone: ____________

ACCIDENT INFORMATION

Date of Accident: __________ Time of Accident: ________ a.m. p.m. Date of Report: __________

Describe the Accident: ______________________________

____

____

____

____

Location of the Accident: ______________________________

____

Describe the Injury: ______________________________

____

____

Describe any Property Loss: ______________________________

____

____

If applicable:

Vehicle Make/Model: ____________________ State/License Plate Number: ____________

Was the visitor a participant in a conference: __ yes __ no Name of conference: ____________________

MEDICAL/TRANSPORTATION INFORMATION

None Provided (✓): ______ Transported by Ambulance (✓): ______

Taken to Hospital/clinic (✓): ______ Driven by friend/Individual (✓): ______

Hospital/clinic name: ______________ Treating Physician: ______________

WITNESS INFORMATION

Name/Address: ______________________________ Daytime phone: __________

Name/Address: ______________________________ Daytime phone: __________

Name/Address: ______________________________ Daytime phone: __________

Completed by: ______________________________ Date: ______________

Revised 10/2023