Public Liability Report

Diocese of Kansas City-St. Joseph

Claim No. _____

REPORT OF ACCIDENT TO PERSONS OTHER THAN YOUR EMPLOYEES

DIOCESAN INSURANCE OFFICE
P.O. Box 419037 Kansas City, Missouri 64141
Phone: (816)756-1850

(1) Location	Name of Parish or Institution
	Address
	Location and Zip Code
(2) Time & Place	Date of Accident Time: am pm
	Date Notice First Received:
	Location of Accident - Address:
	Church School Rectory Hall Convent Playground Other
(3) Injured Person	Name:
	Address:
	City, State, Zip Code:
	Telephone: Home: Business:
(4) The Injury	Nature & Extent of Injury:
	Where was injured taken after accident?
	Name of Doctor:
	Address of Doctor:
(5) Property Damage Only	Owner: Address: Bus.Tel. Res. Tel.
(6) Witness	
(7) Description of Accident	
	Date, Location and Badge Number or Complaint Number of Police Authority to Whom Accident Was Reported:

_____ _____

Signature of Pastor or Administrator Date

Diocese of Kansas City-St. Joseph
Participant Accident Report Form

School/Center _____ Date _____

This form is to be completed on any accident which results in:

- *an injury severe enough to cause a participant's absence for one half day or more from school/center; or*
- *injury severe enough to require a doctor's attention (accidents that happen at school/center or sponsored events only).*

A copy of this form is to be put in the participant's cumulative file. It must be kept permanently.

Participant Information

Name _____ Home address _____

Name of Parent/Guardian(s) _____

Grade _____ Age _____ Date of Accident _____ Time of Accident _____

Description of the Accident

Location _____ *Instructor on Duty* _____

*Nature of Injury*_____

How did the accident happen? What was the participant doing? Where was the participant? How did the participant describe the accident? List any unsafe acts or conditions existing.

Instructor's remarks:

Nurse/Volunteer's remarks:

Use back of form if needed

Action taken:

First aid treatment by _____

Sent home by _ *Sent to school nurse by* ____

Sent to physician by _____

Physician's name _____

Name of hospital (if used) _____

Was anyone else notified? Who? Time?

Was parent notified _____ *Time* _____ *Number of school days lost* _____

Name(s) of any witnesses to the accident: _____

*Signature of Nurse/Volunteer*_____

*Signature of Instructor*_____