



Student Accident Report

TEXAS CHRISTIAN UNIVERSITY

Return form to:

TCU Risk Management
Box 297110, Fort Worth, TX 76129
817-257-7475

STUDENT CONTACT INFORMATION

Name: _____ Daytime phone: _____
Address: _____ Evening phone: _____
City/State: _____ Age: _____ Sex: _____ SSN or TCU ID number: _____

Please complete if the student is a paid employee.

Is the student a paid employee of the university: ___ yes ___ no Was the student injured performing job duties: ___ yes ___ no

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: _____

TRANSPORTATION INFORMATION

Check all that apply:

None Provided: _____
Taken to Health Center: _____
Taken to Hospital: _____

Transported by Ambulance: _____
Driven by friend/Individual: _____
Transported by Campus Police: _____

If applicable:

Treatment Refused: ___ yes ___ no Name of Hospital: _____ Treating Physician: _____

WITNESS INFORMATION

Name/Address: _____ Daytime phone: _____
Name/Address: _____ Daytime phone: _____
Name/Address: _____ Daytime phone: _____
Name/Address: _____ Daytime phone: _____

Completed by: _____ Date: _____