



ACCIDENT AND INJURY REPORT

Reporting Party Information

First Name _____ Affiliated Club/Organization _____
Last Name _____ Phone _____
Title _____ Email _____

Injured Party Information

First Name _____ Address _____
Last Name _____ City _____
Phone _____ Postal Code _____
Email _____ Date of Birth _____
Gender _____ CASSA# _____
Affiliated Club/Organization _____

Accident or Injury Information

Date _____ Time _____ Facility Name _____
Address _____ City/Province _____
Location on site (Be specific) _____
Activity at the time of accident _____
Activity Supervisor at the time of accident or injury _____
Was the activity sanctioned/approved? YES / NO

Describe the Accident and injury and include affected body parts (specify R or L) _____

On Site Care Given by what specialist? _____

Name of person giving care _____

What care was given on site _____

Parent/Guardian notified? YES / NO

Taken to Clinic/Hospital? YES / NO If yes, Location? _____

Care refused by Injured? YES / NO

If yes, Signature of Injured or Guardian if under 18 years of age _____

Health Insurance Information

Do you have provincial Health Coverage? YES / NO

Do you have other insurance? YES / NO

If yes, please provide name of insurance company _____

Witnesses

Please include names of two (2) witnesses and attach the completed witness reports:

First Name _____

First Name _____

Last Name _____

Last Name _____

Phone _____

Phone _____

Email _____

Email _____

Signature

Date



WITNESS ACCIDENT AND INJURY REPORT

Witness Information

First Name _____ Affiliated Club/Organization _____
Last Name _____ Phone _____
Title _____ Email _____

Injured Party Information

First Name _____ Last Name _____
Gender _____ Affiliated Club/Organization _____

Accident or Injury Information

Date _____ Time _____ Facility Name _____
Address _____ City/Province _____
Location on site (Be specific) _____
Activity at the time of accident _____
Activity Supervisor at the time of accident or injury _____
Describe the Accident and injury and include affected body parts (specify R or L) _____

On Site Care Given by what specialist? _____
Name of person giving care _____
What care was given on site _____
Taken to Clinic/Hospital? YES / NO If yes, Location? _____
Care refused by Injured? YES / NO

Signature

Date

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