Clear Form

Accidental Injury Report

Cañada ☐ CSM ☐ Skyline ☐	Sent to: SMCCCD 3401 CSM Drive San Mateo, CA 94402	
Date/Time of Injury:		
Campus Location:		
Injured Person's Name & Address:	Date of Birth: SS# Tel#:	
Student ☐ Visitor ☐ Employee ☐		Male ☐ Female ☐
Description of Accident:		
Description of Injury:		
Witness(es) Name & Tel#: (1)	(2)	
Was any care administered immediately after injury? By whom?		
Additional help summoned? College Nurse ☐ 911☐ Campus Security ☐ Other ☐		
Insurance Coverage: yes ☐ No ☐ If yes, policy number: _____		
Claim form given? Yes ☐ No ☐ (Student Accident Insurance is a secondary. If the injured person has insurance, she/he must use hers/his.)		
Name of the Employee who prepare the form:	Signature:	Date: