CATHOLIC DIOCESE OF ARLINGTON

Office of Risk Management

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CATHOLIC SPORTS CLUB INCIDENT REPORT

PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE ABOUT THE ACCIDENT.
*****PLEASE PRINT*****

Name of Location (School/Parish): _____

Location Address: _____

Name of Injured Participant _____ Gender: ☐ M ☐ F **DOB**: _____
mm/dd/yyyy

Participant's **Complete** Mailing Address:

STREET _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL _____

Date of Accident (mm/dd/yyyy): _____ Time: _____

Nature and Type of Injury (e.g., right arm, left leg, etc.): _____

Does the participant have medical insurance? ☐ Yes ☐ No ☐ Unknown

***If YES,*

Insurance Company: _____ Policy Number: _____

Did the injury require medical treatment after accident? ☐ Yes ☐ No ☐ Unknown

***If YES, a DOB and home address is required.*

Detailed Description of Accident (use back for additional space):

_____

_____

_____

_____

_____

Description of Aid Given: _____

_____

Witness Name: _____ Phone #: _____

Name of Person Completing Report: _____ Phone #: _____

Title/Position of Person Completing Report: _____

Signature of Person Completing Report _____

RETURN COMPLETED FORM TO RISK MANAGEMENT
riskmanagement@arlingtondiocese.org
FAX: 703-778-9118