



ACCIDENT REPORT FORM

Volunteer's Name: _____ Volunteer Position: _____

Supervisor's Name: _____ Department: _____

Date and Time of Accident: _____ Location: _____

Task being performed when accident occurred:

Name(s) of witness(es): _____

Describe how the accident occurred with any relevant details:

Describe injuries that were sustained with any relevant details:

When was medical attention first sought? Date: _____ Time: _____

Name of doctor and/or hospital: _____

What, if anything could have been done to prevent the accident?

Signature _____ Date _____
(Staff person/supervisor)

Signature _____ Date _____
(volunteer)

Please return to the VIP Coordinator at:
Volunteer Initiative Program
701 Ocean Street Room 30
Santa Cruz, CA 95060