St. Clair County Community Mental Health

Non – Employee Accident Report

Complete and submit to Safety Coordinator within 24 hours.

Injured person: _____
(First Name) (Middle Initial) (Last Name)

Home address: _____
(Street) (City/State) (Zip)

Date of birth: _____ Phone number: _____

Date of accident: _____ Time of accident: _____A.M. _____P.M.

Location of accident: _____
(CMH building or address)

Reason for visit to building: _____

Body part injured: _____ Type of injury: _____
(arm, leg, etc.) (scratch, cut, burn)

Reported by: _____ Staff phone number: _____
(CMH staff)

Case number (if applicable): _____ Police report number (if applicable): _____

Describe clearly how the accident happened:

Signature of injured person_____

Name of witness: _____ Phone number: _____

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Suggestions to prevent re-occurrence:

Date received by CMH Administration: _____ Accident report number: _____