Foster Grandparents Program of Cleveland County
Accident Report Form

Volunteer's Name: ____

Date of Accident: ______________________ Time of Accident: ________________________

Place of Accident (be specific):
____

____

Description of Accident (complete details): ____

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____

Type of First Aid Given: ____

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____

Name of Person Treating Volunteer: ____

Was a Physician called? __________ If Yes, Name: ___________________________________

Witnesses to the Accident: (get information on two people if possible):

1) Name:____

Address: ____

2) Name: ____

Address: ____

Name and Address of person completing this form: __________________________________

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⇒ **For insurance purposes, this form must be completed when an accident occurs (no matter how minor) and be in our office no later than 24 hours from the time of the incident.**