ANTELOPE VALLEY COLLEGE

DEPARTMENT OF HUMAN RESOURCES
OFFICE OF RISK MANAGEMENT

STUDENT WORKER/ STUDENT IN CLINICAL ROTATION STATEMENT OF ACCIDENT

Please Print

Student Name: _____

Birth date: _____ Sex: _____ Social Security Number: _____

Residence Address: _____

City: _____ State: _____ Zip: _____

Residence Telephone: (_____)_____ District extension: _____

Date of Accident: _____ Time: _____ a.m. p.m.
(month/day/year)

Specific point at location where accident occurred (campus location or medical facility name & address; include room number or other description):_____
_____

Witness(es) to the accident: _____
_____
_____

Description of how the accident occurred: _____
_____
_____
_____

Part of body affected (i.e back, left wrist, right eye, etc.)?: _____
_____

Time you began work on the day of the incident? _____ a.m. p.m.

Time you began clinical rotation on the day of the incident? _____ a.m. p.m.

What is your regular schedule? M T W TH F Hours per day:_____

Hours per week:_____ Your immediate supervisor: _____

How could the accident have been prevented? _____
_____

_____ _____
Student Signature Date