

INCIDENT REPORT FORM: DIOCESE OF OWENSBORO

Parish Event Deanery Event Diocesan Event

Date of the Incident _____ Time of the Incident _____

Name of the Victim _____ Age _____

Address of the Victim _____

Parent/Guardian of Victim _____

Phone Number (Day) _____ Phone Number (Evening) _____

Location of the Incident (Name of facility/ where in that facility) _____

Person(s) Who Witnessed the Incident:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Describe how the incident happened. _____

What were the apparent injuries? _____

How and by whom were the injuries treated at the scene? _____

What additional medical assistance was sought? _____

What (if any) hospital or medical facility was used? _____

Was a parent/guardian contacted? Yes _____ No _____ Details: _____

(OVER)

Revised July 2008

INCIDENT REPORT FORM :DIOCESE OF OWENSBORO (Continued)

_____ Parent/Guardian consented to medical treatment.

or _____ Parent/Guardian declined medical treatment.

Why? _____

Who contacted the parent/guardian? _____

What happened after the hospital/medical facility treatment (if applicable)? _____

Present Condition of the Victim _____

Name of Person Submitting Incident Report _____

Title of Person Submitting Incident Report _____

Date Report Completed _____

Mail or FAX a copy of this report (24 hours minimum to two weeks maximum) to:

Chancellor/Administration
600 Locust Street
Owensboro, KY 42301
270-683-1545
FAX: 270-683-6883

Indicate on chart below the area(s) of injury.

