Appendix J.

WayCAM.tv
Wayland Community Media Center

268 Old Connecticut Path, Wayland, MA 01778 – (508)358-5006 – waycam@waycam.tv

Accident or Injury Report

Please submit one form for each person involved.

Name of person involved: ____ Date: ______________

Address: ____ City: __________________ Zip: ___________

☐ Student ☐ Member ☐ Staff ☐ Volunteer ☐ Other ________________ Phone: _______________

Date and Time: ______________________

Did accident occur while performing WayCAM related activity? ☐ No ☐ Yes

Was a vehicle involved? ☐ No ☐ Yes (please fill in the grey box below)

Print Owner's Name: ___________________________________ Vehicle Plate No.: _____________

Address: __________________________________ City: ____________State:_____ Zip:_________

Where did this happen: ____

Describe what happened: ____

____

Describe what else was happening when this occurred: ____________________________________

____

Did someone else see what happened? ☐ No ☐ Yes (please fill in the grey box below)

Please give us their names and contact information:

1) ____

2) ____

3) ____

Who was notified about the accident/incident?

☐ No one ☐ Police ☐ Parent ☐ School Official ☐ Spouse ☐ Other: _______________________

Please list name and contact information: ____

WayCAM Accident or Injury Report – page 2

Was the person injured? ☐ No ☐ Yes (please fill in the grey box below)

Please describe the injury: ____

____

Was any first aid given at the scene? ☐ No ☐ Yes (please fill in the white box below)

What type? ____

Who administered first aid? Name: ______________________ Title ______________

Contact Information: ____

Was the person transported to hospital or clinic? ☐ No ☐ Yes (please fill in the white box below)

Name of facility: ______________________ Phone: ______________

Medical provider(s): ____

Address: ______________________ City: ______________________

Describe treatment provided: ____

____

____

Name & Signature of person completing this form:

Name (print): ____ Date: ______________

Signature: ____ Phone: ______________

Address: ______________________ City: ______________ Zip: ____________

I am the person involved: ☐ No ☐ Yes

WayCAM Accident or Injury Report – page 3

Please fill this page out if the person involved is a WayCAM employee.

Did employee miss any work as a result of accident? ☐ No ☐ Yes (if yes, fill in the grey box below)

First date missed: ___________________ Date returned to work: ___________________

Has employee filed for Worker's Compensation insurance? ☐ No ☐ Yes

Additional Notes: ____

____

____

Injured Person's Signature: ____________________________________ Date: ___________________

Supervisor's Name: ____________________________________ Date: ___________________

Supervisor's Signature: ____________________________________