Allegheny West Conference
Covenant Insurance Group

Medical Incident Report

Policyholder Information

Church's Name:_____

Address: _____

Phone: _____ Email: _____

Date reported: _____

Date & Time of Loss_____

Reported by (name)_____Title_____

Primary Contact Person_____

Primary Contact Persons Home #_____ Cell # _____

E- mail_____

Accident Information

Location of Accident: _____

Address: _____

Police or Ambulance Dept Reported to: _____

Description:

Injured Person

Name of Injured Person: _____

Age _____ Sex _____ DOB: _____

Parent/Guardian of minor child: _____

Address: _____

Phone: _____ Email: _____

Health Insurance Information: _____

Injuries: _____

_____

Name of Facility where injured was taken: _____

Address: _____

Was injured transported by Ambulance: _____

Was the accident school related: _____

Did the accident occur: (Please Circle)

a) while the claimant was supervised? Y or N
b) during sponsored activity? Y or N
c) during programmed hours? Y or N
d) on activity premises? Y or N

Witnesses

Witness: _____

Address: _____

Phone: _____ Email: _____

Witness: _____

Address: _____

Phone: _____ Email: _____