BCFL INCIDENT/ACCIDENT REPORT FORM 2010

Date of incident: _____ Time: _____ AM/PM

Team: _____

Location of accident: _____

Name of injured person: _____

Address: _____

Phone Number(s): _____

Date of birth: _____ Male _____ Female _____

Who was injured person? (circle one) Player Volunteer Staff Employee

Type of injury: _____

Details of incident: _____

_____

_____

_____

_____

_____

Injury requires physician/hospital visit? Yes ___ No _____

Name of physician/hospital: _____

Address: _____

Physician/hospital phone number: _____

_____

Signature of injured party parent/guardian Date

_____

Signature of team official Date

_____

Signature of league official Date

Return a copy of this form to BCFL league office within 24 hours of incident.