



## EDC MULTIPURPOSE COMPLEX ACCIDENT/INCIDENT REPORT

Name \_\_\_\_\_

Date of Accident/Incident \_\_\_\_\_

Time of Accident/Incident \_\_\_\_\_

Place of Accident/Incident \_\_\_\_\_

Describe briefly what happened.

Name Witness(es) if any. \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Was Medical Care/Treatment Needed? \_\_\_ Yes \_\_\_ No

Who Administered Care/Treatment? \_\_\_\_\_

If Yes, Explain.

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Signature of individual completing form /Signature of Injured Person

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