NON-EMPLOYEE INJURY/ILLNESS REPORT
This form is to be completed when a non-employee incurs an injury/illness at an A.S. event or within an A.S. facility. Please forward completed form to Contracts & Risk Management Coordinator.

Section 1 – Non-Employee Information

Name _____________________________________________________________ □ Male □ Female
Full Address ______________________________________________________ Phone _______________________
E-mail address _________________________________________________ Date of Birth __________________________
□ Student □ Faculty/Staff □ Minor □ Other __________________________
Date of Injury ____________ Time ____________ □ AM □ PM
Activity/Program______________________________________________________
Location where event/exposure occurred_______________________________

Section 2 – Description of Injury/Illness (Describe specific injury and part of body affected; include visual description of injury/illness. Only include a diagnosis if a medical professional has provided.)

Section 3 – How did the injury occur? (Describe events, actions, conditions that resulted in injury. Describe sequence of events. Specify object or exposure which directly produced the injury/illness. Provide only factual accounts and/or observations.)
Section 4 – Action Taken

Emergency Services Called □ Yes □ No  Time Called______________ Time Arrived ______________
Transported Hospital/Medical Facility □ Yes □ No  Where______________________________
First Aid/Medical Treatment □ Yes □ No  Type ____________________________

Administered by (name & title) ____________________________________________
Medical Treatment Refused □ Yes □ No  Offered by (name & title) ________________
Care of Injured Transferred to: Name __________________________ Relationship __________

Section 5 – Witnesses (if applicable – Please list witness contact information below. Should witnesses be able to provide a written statement, please attach on a separate page. No form or special format required.)

<table>
<thead>
<tr>
<th>Employee Witnesses</th>
<th>Non-Employee Witnesses (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name __________________</td>
<td>Name (First &amp; Last) ____________________</td>
</tr>
<tr>
<td>Title __________________</td>
<td>Phone Number __________________________</td>
</tr>
<tr>
<td>Name __________________</td>
<td>Name (First &amp; Last) ____________________</td>
</tr>
<tr>
<td>Title __________________</td>
<td>Phone Number __________________________</td>
</tr>
</tbody>
</table>

Section 6 – Special Remarks (If applicable, provide additional information regarding the injury/illness that you believe is important.)

Section 7 – Follow Up (This section is to be completed by the Supervisor and/or Director/Assistant Director.)

Prepared by ___________________________ Title ___________________________ Date ______________

Once completed, submit the form to your supervisor for review and processing.

Supervisory review by ___________________________ Title ___________________________ Date ______________

Director/Assistant Director review ___________________________ Date ______________

Please send completed form to Contracts & Risk Management Coordinator.