



DELTA-MONTROSE TECHNICAL COLLEGE

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**DELTA-MONTROSE TECHNICAL COLLEGE
ACCIDENT REPORT**

NAME OF SCHOOL: _____

LOCATION (class): _____

NAME OF STUDENT/EMPLOYEE: BIRTH DATE: _____

ADDRESS: _____ TELEPHONE: _____

PARENT/GUARDIAN: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____

TYPE OF INJURY (be specific): _____

INSTRUCTOR'S STATEMENT ON HOW INJURY OCCURRED: _____

IF ACCIDENT OCCURRED ON A MACHINE, WERE GUARDS IN PLACE: YES NO
NAME TWO (2) EYEWITNESSES TO ACCIDENT:

NAME _____ ADDRESS _____

NAME _____ ADDRESS _____

WHO PERFORMED FIRST AID: _____ POSITION: _____

Was the injured student/employee sent:
 class work home physician hospital

Name and address of Physician or Hospital that gave treatment:

INSTRUCTOR/SUPERVISOR

SAFETY DIRECTOR