FIRST BAPTIST CHURCH OF GLENARDEN
INCIDENT REPORT FORM

Please complete and submit this original form to: Ministry Support Office or fax to 301-341-5660.
Forms should be submitted immediately when possible or not later than 2 to 3 days after incident.

Today's Date: _____ **Date of Report:** _____ **Time:** _____

Report originated from: ☐ Worship Center ☐ Ministry Center ☐ FBCG Ministry Event ☐ FBCG Travel ☐ Other _____

Service: ☐ 8 a.m. ☐ 10 a.m. ☐ Noon ☐ 6:30 p.m. ☐ Other _____

Nature of Report:

Briefly describe nature of incident. (ie cuts, broken bones, theft, damage, dispute)

Date and time incident occurred: _____

Specific location of incident: _____

Complete this section for All individuals involved in the incident.

Name: _____ **Age:** _____ **Membership:** ☐ Member ☐ Guest ☐ Other _____
Home Phone: _____ **Mobile:** _____ **Work Phone:** _____

Name: _____ **Age:** _____ **Membership:** ☐ Member ☐ Guest ☐ Other _____
Home Phone: _____ **Mobile:** _____ **Work Phone:** _____

If minor, were parents or guardians notified? ☐ Yes ☐ No **Please specify:** ☐ Parent ☐ Guardian

Name: _____
Home Phone: _____ **Mobile:** _____ **Work Phone:** _____

Complete this section for witness(es) to the incident.

Name: _____ **Home Phone:** _____ **Mobile:** _____ **Work Phone:** _____
Address: _____ **City:** _____ **State** _____ **Zip Code** _____

Name: _____ **Home Phone:** _____ **Mobile:** _____ **Work Phone:** _____
Address: _____ **City:** _____ **State** _____ **Zip Code** _____

Modified 11/19/12

Briefly describe the incident: _____

Were police notified? ☐ Yes ☐ No **Police Case Number:** _____

If possible, attach a copy of police report.

Briefly describe the injury: _____

Medical Treatment Performed/Offered

Was medical treatment offered and/or required? ☐ Yes ☐ No

If so, by whom? _____ **Contact Number:** _____

Was first aid/treatment provided? ☐ Yes ☐ No

If so, by whom? _____ **Contact Number:** _____

Were any of the following performed?

☐ BP _____ ☐ Temp _____ ☐ Pulse _____ ☐ Other _____

Hospital/Ambulance Information

Was ambulance contacted? ☐ Yes ☐ No **Was person taken to hospital by ambulance?** ☐ Yes ☐ No

Which Hospital? _____

Name of ambulance company and car number? (if available): _____

Did person refuse to be taken to hospital by ambulance? ☐ Yes ☐ No

Ministry Support Follow-Up Report

Follow-Up Date: _____ **Follow-Up Time:** _____

Brief Status: _____

Name of person completing this report: _____

Telephone Number: _____ **Signature:** _____