CONFIDENTIAL

please return within 24 hours of occurence

GREEK ORTHODOX ARCHDIOCESE OF AMERICA
METROPOLIS OF ATLANTA

EVENT INCIDENT REPORT

youth@atlmetropolis.org

TODAY'S DATE _____

AREA OF CONCERN
_____ Bullying
_____ Inappropriate Behavior
_____ Other *(please indicate)* _____
_____ Infraction of Rules/Youth Covenant
_____ Potential Abuse

INDIVIDUALS INVOLVED
_____ Male Female
_____ Male Female
_____ Male Female
_____ Male Female

LIST ANY WITNESSES _____

PLEASE PROVIDE A DETAILED ACCOUNT OF WHAT HAPPENED, INCLUDING LOCATION, WHO WAS NOTIFIED, ANY INJURIES, ETC.

_____
_____
_____
_____
_____
_____
_____
_____

(use reverse or attach additional sheets of paper if needed to fully describe the incident)

DESCRIBE ANY INJURIES (both the extent of the injury and to whom it occurred)

_____
_____
_____

WAS THE INJURED PARTY SEEN BY A DOCTOR OR TRANSPORTED TO A MEDICAL CLINIC OR HOSPITAL? YES NO

IF YES, PLEASE COMPLETE BELOW

DOCTOR NAME _____

HOSPITAL/CLINIC NAME _____

PHONE NUMBERS _____

NAME OF INDIVIDUAL COMPLETING FORM _____

RELATION TO THE INVOLVED PARTIES _____

YOUR CONTACT INFORMATION
phone _____
email _____

YOUR SIGNATURE _____ TODAY'S DATE _____