CITY OF NEW CASTLE
City Building
230 N. Jefferson Street
New Castle, Pennsylvania 16101-2220

NON-EMPLOYEE INJURY REPORT FORM

Name:	
Address:	**Phone:**
	Email:
Incident Location:	**Date of Incident:**
	Time of Incident:
Condition of area where incident occurred:	
Please describe what happened:	
Injury/Accident Details:	

Treatment of Injury:	
Did the injured party miss work due to injury? If so, how many days/hours of work were missed?	
Were there any witnesses to the incident?	
Witness #1 Name:	
Witness #1 Address:	**Witness #1 Phone:**
	Witness #1 Email:
Witness #2 Name:	
Witness #2 Address:	**Witness #2 Phone:**
	Witness #2 Email:

****The completion of this form does not guarantee or accept liability/fault for an injury, nor does it guarantee the filing of an insurance claim.****

For City Use Only:

Form Received By:	
Job Title:	**Date:**
Signature:	