HAZING REPORT FORM FOR ORGANIZATIONS

NOTE:

1. **This standardized form, developed by the Board of Regents pursuant to Act 382 of 2019, is to be used by organizations affiliated with postsecondary institutions to report any information received by the organization regarding incidents of hazing.**
2. **Organizations must send this report to law enforcement and the affiliated institution as soon as practicable.**
3. **This report contains unredacted information, as required by Act 382 of 2019. Subsequent use and disclosure of this report remains subject to applicable laws and regulations, including the Family Educational Rights and Privacy Act and the Health Insurance Portability and Accountability Act.**

INFORMATION ABOUT ORGANIZATION			
Name of Organization: University of Louisiana at Lafayette Affiliated Institution Name of Affiliated Parent or National Organization			
Full Name and Title of Contact Official at the Organization			
Address			
Phone Numbers	Home	Cell	Work
INFORMATION ABOUT PERSON(S) INVOLVED IN THE INCIDENT (USE ADDITIONAL FORMS FOR EACH PERSON INVOLVED)			
Full Name			
Affiliated Organization (Member or Pledge) Home Address			
Phone Numbers	Home	Cell	Work
INFORMATION ABOUT THE INCIDENT			
Date of Incident	Time	Police Notified ☐ Yes ☐ No	
Location of Incident ☐ On campus ☐ Off- campus Specific Location			
Description of Incident (what happened, how it happened, individuals involved, factors leading to the event, etc.) Be as specific, complete and accurate as possible and do not redact any information known to the institution official(s) (attached additional sheets if necessary)			
Were there any witnesses to the incident? ☐ Yes ☐ No If yes, attach separate sheet with names, addresses, and phone numbers.			
Was the individual injured? If so, identify the individual and describe the injury (e.g. laceration, sprain, etc.), location of injury (e.g. upper arm, shoulder), and any other information known about the resulting injury			
Was medical treatment provided? ☐ Yes ☐ No ☐ Refused If yes, where was treatment provided: ☐ on site ☐ Urgent Care ☐ Emergency Room ☐ Other			
REPORTER INFORMATION			
Individual Submitting Report (print name)			
I hereby affirm that the information contained in this report is complete and accurate to the best of my knowledge. Signature: Date Report Completed:			

FOR OFFICE USE ONLY

Report Received by_____ Date_____

DOCUMENT ANY FOLLOW-UP ACTION TAKEN AFTER SUBMISSION OF THE INCIDENT REPORT

Date	Action Taken	By Whom