GRAMBLING STATE UNIVERSITY®

# HAZING REPORT FORM FOR INSTITUTIONS

1. This Standardized form, developed by the Board of Regents pursuant to Act 382 of 2019, is to be used by postsecondary institutions to report to law enforcement as soon as practicable, any information received by any official at the institution regarding incidents of hazing.
2. This report contains un-redacted information, as required by Act 382 of 2019. Subsequent use and disclosure of this report remains subject to applicable laws and regulations, including and the Family Educational Rights and Privacy Act and the Health Insurance Portability and Accountability Act.

| INFORMATION ABOUT ORGANIZATION | | | |
|---|---|---|---|
| Name of Institution<br>Name of Affiliated Organization(s) Relevant to the Incident | | | |
| Full Name and Title of Contact Official at the Institution | | | |
| Address | | | |
| Phone Numbers | Home | Cell | Work |
| **INFORMATION ABOUT PERSONS(S) INVOLVED IN THE INCIDENT (USE ADDITIONAL FORMS FOR EACH PERSON INVOLVED)** | | | |
| Full Name: | | | |
| Attending Institution<br>Affiliated Organization (Member or Pledge)<br>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_____<br>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) (attach additional sheets if necessary) | | | |
| Were there any witnesses to the incident _____Yes or, _____No<br><br>If yes, attach separate sheet with names, addresses and phone numbers | | | |
| Was anyone 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<br>If yes, where was treatment provided: ___On site ___Urgent Care _____Emergency Room ___Other<br><br>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.<br><br>Signature_____Date_____ PRINT | | | |
| FOR OFFICE USE ONLY | | | |

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DOCUMENT ANY FOLLOW-UP ACTION AFTER SUBMISION OF THE INCIDENT REPORT

List any follow-up action taken after submission of the incident report, date action taken, and by whom

| Date | Action Taken | By Whom |
|---|---|---|
| | | |
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