



HAZING REPORT FORM FOR INSTITUTIONS

NOTE:

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 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 INSTITUTION			
Name of Institution: University of Louisiana at Lafayette			
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 PERSON(S) INVOLVED IN THE INCIDENT (USE ADDITIONAL FORMS FOR EACH PERSON INVOLVED)			
Full Name			
Attending Institution			
Affiliated Organization (Member or Pledge)			
Home Address			
Phone Numbers	Home	Cell	Work
INFORMATION ABOUT THE INCIDENT			
Date of Incident	Time	Police Notified <input type="checkbox"/> Yes <input type="checkbox"/> No	
Location of Incident <input type="checkbox"/> On campus <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused If yes, where was treatment provided: <input type="checkbox"/> on site <input type="checkbox"/> Urgent Care <input type="checkbox"/> Emergency Room <input type="checkbox"/> 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