BRIARCLIFF MANOR UFSD
EMPLOYEE ACCIDENT/INCIDENT REPORT

Name: ____

Address: ____

Date of Birth: ____________________ **Soc. Sec. #** ________________

Occupation: _______________________________________

Date of Accident: _________________ **Time of Accident:** __________

Place of Accident: _________________________________

First Aid Rendered: (if none, indicate none) ______________________

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Did Employee receive medical care at time of Accident? ____ **Yes** ____ **No**

Name and address of Doctor or Hospital: ________________________

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Nature of injury (include body part and state right or left): ____________

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What was Employee doing at time of accident? ____________________

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Name of Witnesses: ________________________________

Was there time lost due to accident? ___________________________

Nurse or Supervisor's Signature: _____________________________

Date: ______________________________________