BRIARCLIFF MANOR UFSD

EMPLOYEE ACCIDENT/INCIDENT REPORT

Please send completed form to Tracy Segelbacher, tsegelbacher@briarcliffschools.org
AND Erika Gomez, egomez@briarcliffschools.org

Employee Name_____

Address: _____

Date of Birth:_____**S.S.#**_____

Position/Occupation:_____

Date of Accident:_____ **Time of Accident:**_____

Place of Accident:_____

Detailed Description of incident, including events leading up to the incident and how the incident ended: _____

_____

_____

_____

_____

_____

_____

First Aid Rendered: (If none, indicate none)_____

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

Name and address of Doctor or Hospital:

_____

_____

_____

Nature of injuries arising from the incident (include body part and state right or left):_____

_____

_____

_____

_____

What was employee doing at time of accident? Must Explain:_____

_____

_____

_____

_____

Name of Witnesses: _____

Was there time lost due to accident? _____

Nurse or Supervisor's Signature: _____

Date: _____

Did this incident result in the actions of another individual (Y/N)?: _____

Name of Individual #1:_____ Job Title of Individual #1: _____

Name of Individual #2: _____ Job Title of Individual #2: _____

**If there are additional individuals involved, please write in their names and titles if applicable.*

Does this incident involved workplace violence (Y/N)?: _____

Supervisor's Signature: _____

Date: _____

***Note**: Employees who are victims of workplace violence can independently and voluntarily request that their name not be entered on the report.*