ABC AGENCY ACCIDENT/INCIDENT REPORT FORM

Date of incident: _______________ Time: _______ AM/PM
Name of injured person: ____
Address: ____
Phone Number(s):____
Date of birth: __________________________ Male _______________ Female ________________
What type of accident: ____
Who was injured person? (circle one): Person Supported Employee
Type of injury:
____
____
Name of Eyewitness to the accident: ____
Details of incident: ____
Injury requires physician/hospital visit? Yes _____ No _____
Personnel called 911 Emergency? _____ yes ______ no
Name of physician/hospital: ____
Address: ____
Physician/hospital phone number: ____

Signature of injured party:
____

Date: ___________________________

Check here if no medical attention was desired and/or required: ______

Signature of injured party:
____

Date: ___________________________

Return this form to Safety Coordinator within 24 hours of the incident.