

EMPLOYEE ACCIDENT/INCIDENT REPORT FORM

Name of Aide/Attendant (First, MI, Last): _____

Address (Street, City, and ZIP code): _____

SSN: _____ Date of birth: _____ Age: _____

Date and time of occurrence: ____/____/____, _____ am pm

Location of Accident/Incident: _____

Were witnesses present? [] YES [] NO If yes, please include name and phone number:

Describe in your own words what happened:

What action was taken? _____

If you were injured, please note which part of your body was involved: _____

Did you (or will you) see a physician? [] YES [] NO Date: ____/____/____

Physician's name and address: _____

Were you able to continue work? [] YES [] NO

If no, date and time of last visit performed: ____/____/____ _____ am pm

Date of probable return to work : ____/____/____

Please mark who was notified: Police [] Ambulance [] AOI on-call [] Other []
AOI administrator []

Name of administrator or other: _____

Signature: _____ Date: _____
