

**CLIFFSIDE PARK BOARD OF EDUCATION
CLIFFSIDE PARK, NEW JERSEY 07010**

EMPLOYEE ACCIDENT REPORT FORM

NAME:	Date of Accident:
ADDRESS:	Time of Accident:
HOME PHONE:	Date of Birth:
JOB TITLE:	SS #:
SCHOOL:	Salary:
DEPT. WHERE EMPLOYED:	
WHERE DID ACCIDENT OCCUR: (school, etc.)	
HOW DID ACCIDENT OCCUR:	
WHAT WAS EMPLOYEE DOING WHEN INJURED: (be specific)	
OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE:	
NATURE OF INJURY OR ILLNESS AND PART OF BODY AFFECTED:	
<hr/> NURSE'S ASSESSMENT;	
FIRST AID TREATMENT: (if any) _____	
ADMINISTERED BY:	
REPORTED TO QUALCARE (1-800-425-3222) (circle one) YES NO	
NAME OF DOCTOR: (if any) _____	
ADDRESS OF DOCTOR:	
NAME OF HOSPITAL: (if any) _____	
ADDRESS OF HOSPITAL:	
NAMES OF WITNESSES: (if any)	

REMARKS:	
Date of Report: _____ Principal's Signature: _____	