



ACCIDENT/INCIDENT REPORT FORM
Return to HR within 24 hours of Incident.

Date of Incident: _____ **Time:** _____ **AM/PM**

Name of Person Injured: _____

Address: _____

Phone number(s): _____

Date of birth: _____

Who was Injured Person? (please circle one): Client Visitor Employee

Name of the Program and Employee Title (if applicable):

Type of Injury: _____

Details of Incident (Who, What, Where, When, Nature of Injury & Body Part(s) Injured):

Witnesses and their Observations:

Did the injury require a physician/hospital visit? Yes ___ No ___

Reason for injured person to be in/at facility and treatment (if needed):

Name of physician/hospital: _____

Address: _____

Physician/hospital phone number: _____

Witness Signature(s): _____

Date

Date

Signature of injured party: _____

Date

Signature of Veteran or Authorized Representative

Date

Signature of VDC Program Manager

Date

Signature of HR with date received

Date

Signature of Executive Director

Date

email to HR@NHcare-c.org or mail to Human Resources NH Collaborative, 105 Castle St. Keene NH 03431