



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 Director _____ Date _____

Signature of Law enforcement *if needed* _____ Date _____

Note for Dawn: Please notify Executive Director, Safety Officer, and Executive Assistants