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:

NURSE'S ASSESSMENT:

FIRST AID TREATMENT: (if any)_____

ADMINISTERED BY:

REPORTED TO QUAL-LYNX (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:_____