



Union County Educational Services Commission
Employee Accident & Incident Report

THIS SECTION TO BE COMPLETED BY EMPLOYEE

Employee's Name _____ School/Program _____
Last First

Address _____

Date of accident _____ Exact location of accident _____

Time of accident _____ Witnesses _____

Please provide details of accident.

THIS SECTION TO BE COMPLETED BY NURSE

Date accident reported to the school's nurse _____

Nature and extent of injury _____

Was first aid given? If yes, please detail. _____

Date Consolidated Services Group notified at 800 293-9795 ext. 1 _____

Was doctor or dentist consulted? If yes, please provide name and address. _____

Signature of Nurse _____ Date _____

Signature of Principal/Director _____ Date _____