Dutchess BOCES

DUTCHESS BOCES EMPLOYEE ACCIDENT REPORT

Please type or print in ink and submit to supervisor within 24 hours.

Name		Date of Birth
Street Address		
City	State	Zip
Home Phone	Work Phone	Gender Male ☐ Female ☐
Title		Date of Employment
Date of Accident	Time	Building/Location
Brief description of accident		
State nature of injury and part(s) of body affected		
Employee seen by nurse Yes ☐ No ☐	If yes, date and time	School Nurse – Name
Describe treatment by school nurse		
Employee taken to hospital Yes ☐ No ☐	If yes, date and time	Mode of transportation to hospital
Hospital – Name	Hospital – Street Address	Hospital – City, State, Zip
Employee seen by doctor Yes ☐ No ☐	If yes, date	Doctor – Name
Doctor – Street Address		Doctor – City, State, Zip
Dates lost due to injury		
A. Witness #1	B. Witness #2	C. Witness #3
Supervisor – Name	Supervisor – Title	Supervisor – Date Notified
Report completed by		Title
Other comments		
Supervisor's Signature		Date

COMPLETED FORM WITH SUPERVISOR'S SIGNATURE SHOULD BE FORWARED TO:
DUTCHESS BOCES BENEFITS OFFICE, 5 BOCES ROAD, POUGHKEEPSIE, NY 12601