ND Senior Career Development (ND SCD)

FAX to 701 456 1199

ACCIDENT REPORT

State _____

County _____

PLEASE SUBMIT THIS REPORT TO ND SCD WITHIN 24 HOURS OF ACCIDENT

DATE OF ACCIDENT	TIME OF ACCIDENT ☐ A.M. ☐ P.M.	DATE ACCIDENT REPORTED TO SUPERVISOR	PROPOSED RETURN TO WORK DATE

PARTICIPANT'S NAME	SOCIAL SECURITY NUMBER	ASSIGNMENT

MARITAL STATUS	GENDER	BIRTH DATE

HOME ADDRESS	HOME PHONE NO. ( )

HOST AGENCY ADDRESS	WORK PHONE NO. ( )
	HOST AGENCY PHONE NUMBER (IF DIFFERENT THAN ABOVE) ( )

EXACT LOCATION OF ACCIDENT

WHAT WAS THE PARTICIPANT DOING AT THE TIME OF THE ACCIDENT?

HOW DID THE ACCIDENT HAPPEN?

DESCRIBE THE INJURY AND PART OF BODY INJURED

NAMES, ADDRESSES, AND PHONE NUMBERS OF WITNESSES

IN THE OPINION OF THE SUPERVISOR, WHAT WAS THE APPARENT CAUSE OF THE ACCIDENT? *(Identify the unsafe condition or act)*

LOST TIME? ☐ Yes ☐ No	FIRST AIDE ADMINISTERED? ☐ Yes ☐ No	HAS PARTICIPANT SEEN A DOCTOR? ☐ Yes ☐ No

NAMES, ADDRESS, AND PHONE NO. OF HOSPITAL WHERE PARTICIPANT WAS TAKEN

DOCTOR'S NAME, ADDRESS, AND PHONE NO.

WHAT MIGHT HAVE BEEN DONE TO PREVENT THE ACCIDENT?

CORRECTIVE ACTION TAKEN BY SUPERVISOR

ADDITIONAL CORRECTIVE ACTION RECOMMENDED

ATTACH ADDITIONAL PAGES IF NECESSARY

SUPERVISOR'S SIGNATURE	DATE
PARTICIPANT'S SIGNATURE *(If applicable)*	DATE