ANTELOPE VALLEY COLLEGE

Office of Human Resources & Employee Relations

INCIDENT REPORT

Please complete if not filing a workers' comp claim or not seeking treatment by a doctor

Please Print

Name: _____ Date of Birth: ____/__/____

Address: _____ Phone #: ( )_____-_____

City: _____ State:_____ Zip:_____

District extension:_____ Date of Incident: ___/__/___ Time of Incident:_____ a.m. p.m.

Title:_____ Department:_____

Location where incident occurred (if different than AVC, provide name of location & address:) _____

_____

Witness(es) to the incident? Yes____ No___ if yes, name(s)_____

_____

Description of how incident occurred:_____

_____

_____

_____

Part of body affected (i.e. back, left wrist, right eye, etc.)?_____

_____

Tme you began work on the day of the incident?_____ a.m. p.m.

Time you began clinical rotation on the day of the incident?_____ a.m. p.m.

What is your regular schedule? (circle) M T W TH F Hours per day:_____

Hours per week:_____ Social Security #:_____

Name of your immediate supervisor: _____

How could the incident have been prevented?_____

Signature of person who experienced incident: _____ Date:____/__/____

Supervisor signature:_____ Date:____/__/____

Additional comments: