Syracuse City School District

Employee Injury and Illness Report

To be Completed by Employee

SYRACUSE CITY SCHOOL DISTRICT
725 Harrison Street
Syracuse, New York 13210

Case No. _____

Date of Injury ____/____/____ (month / day / year)

TO BE COMPLETED BY EMPLOYEE

Social Security # required	Name (Last) (First) (MI)	Sex (M or F)	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Home Address	City	State	Zip	Home #	Work #

Date of Birth ____/____/____ (month / day / year)	Age	Job Title	Department	Work Location (School Bldg or Site)

Work Status: ☐ Full time ☐ Part time	Hours per Day	Date of Hire:	Immediate Supervisor

Injured body part / areas RIGHT ☐ LEFT ☐	Where did accident occur? (parking lot, hallway, room #) Please be specific:
Time of Day injury or accident occurred: ____:____ AM or ____:____ PM	Date supervisor advised: ____/____/____ (month / day / year)

Is this a recurrence of a previous injury or illness? ☐ Yes ☐ No If "YES" please give details _____

Employee's Statement

Please describe in detail how the injury occurred. Include what the situation was and any objects or tools involved:

How did the accident occur? (Explain how it happened) _____

Was or will medical care be provided other than by school nurse? ☐ Yes ☐ No If yes, please complete the following:

Doctor's Name	School Nurse's Name	Emergency Room Location
Doctor's Address	School	Hospital

Were there any witnesses to the accident? ☐ Yes ☐ No If yes, please complete the following:

Witness Name: _____ Was the witness a District employee? ☐ Yes ☐ No Witness Phone #: _____

Witness Name: _____ Was the witness a District employee? ☐ Yes ☐ No Witness Phone #: _____

If witness is not a District employee, please provide address: _____

_____ *Employee Signature*

____/____/____ *Date*

"Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, self-insurer or purported insurer, or any agent thereof, any written statement as part of or in support of a claim for benefits containing any false, incomplete, or misleading information commits a fraudulent insurance act."

Syracuse City School District

EMPLOYEE INJURY AND ILLNESS REPORT

Employee Name_____ **Date of Injury or Illness**____/____/____

Supervisor's Investigation / Report: This section must be completed by the supervisor prior to signing.

TO BE COMPLETED BY SUPERVISOR

1. Cause Analysis: Describe the factors contributing to this incident.

2. Work Status: Is the employee missing time from work: ☐Yes ☐No ☐Unknown at this time

   If Yes, how much time has employee missed? _____

3. Recommended Corrective Actions: What actions can / will be taken to prevent recurrence of this incident?

_____ _____/_____/_____

Supervisor's Signature Date

Instructions

- *The lead secretary/building designee is to email the Employee Injury Report immediately to Risk Management at:*

WCCLAIMS@SCSD.US

- *Page 2 of this report needs to be completed by the employee's immediate supervisor.*
- *The original completed form should be kept in the building*
- *The supervisor is to follow up on the recommended corrective actions.*