

Employee Injury and Illness Report
 To be Completed by Employee

Case No. _____

Date of Injury ____/____/____
 month day year

TO BE COMPLETED BY EMPLOYEE

Social Security # <u>required</u>	Name (Last)	(First)	(MI)	Sex (M or F)	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> 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: <input type="checkbox"/> Full time <input type="checkbox"/> Part time		Hours per Day	Date of Hire:	Immediate Supervisor	
Injured body part / areas RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/>			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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 #: _____

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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."



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.

NOTICE OF NON-DISCRIMINATION

The Syracuse City School District hereby advises students, parents, employees and the general public that it is committed to providing equal access to all categories of employment, programs and educational opportunities, including career and technical education opportunities, regardless of actual or perceived race, color, national origin, Native American ancestry/ethnicity, creed or religion, marital status, sex, sexual orientation, age, gender identity or expression, disability or any other legally protected category under federal, state or local law.

Inquiries regarding the District's non-discrimination policies should be directed to:

Civil Rights Compliance Officer
Syracuse City School District
725 Harrison Street • Syracuse, NY 13210
(315) 435-4131 or email: CivilRightsCompliance@scsd.us