



GREAT NECK UNION FREE SCHOOL DISTRICT
 345 LAKEVILLE ROAD
 GREAT NECK, NY 11020
 516-441-4070

DOCTOR'S ACCIDENT UPDATE REPORT

Download additional forms at GNPS homepage/staff/GNPS forms/business services/doctor accident update

*****IMPORTANT***** COMPLETED FORM MUST BE SUBMITTED TO *PAYROLL* AFTER 3 CONSECUTIVE DAYS OR MORE OF ABSENCES DUE TO INJURY. FOR CONTINUAL ABSENCES, SUBMIT FORM BY THE 1ST AND 15TH OF EACH AND EVERY MONTH WHILE YOU ARE OUT. FAILURE TO DO SO MAY RESULT IN DELAY OF PAYCHECK.

******PAYROLL FAX # 516-441-4925******

TO BE COMPLETED BY EMPLOYEE

DATE OF ACCIDENT _____

EMPLOYEE NAME _____ SCHOOL OR LOCATION _____

EMPLOYEE ADDRESS _____

HAVE YOU RETURNED TO WORK? YES NO IF YES, DATE RETURNED _____

IF YOU HAVE NOT RETURNED, WHEN WAS YOUR LAST DAY WORKED? _____

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, or self-insurer, any information containing any false material statement or conceals any material fact, shall be guilty of a crime and subject to substantial fines and imprisonment. By signing this report, I confirm that all information submitted is true and accurate to the best of my knowledge and belief. I acknowledge that it is a crime to make false statements on a government document, file a false instrument or steal government services. The District reserves the right to terminate employment, initiate civil or criminal action, including but not limited to fraud and/or perjury, in the event of such falsification.

EMPLOYEE SIGNATURE _____ DATE _____

TO BE COMPLETED BY DOCTOR

IS EMPLOYEE ABLE TO WORK? YES NO CAN EMPLOYEE WORK WITH MODIFIED DUTIES? YES NO
 IF YES, PLEASE INDICATE RESTRICTIONS _____

IF DISABLED (UNABLE TO WORK), PLEASE INCLUDE CLINICAL DIAGNOSIS AND DESCRIBE PRESENT CONDITION:

IF EMPLOYEE IS CONTINUOUSLY DISABLED (UNABLE TO WORK), PLEASE SUPPLY DATE DISABILITY BEGAN:
 FROM _____ TO _____

WHEN DO YOU ANTICIPATE EMPLOYEE CAN RETURN TO WORK? _____

LIST DATES OF VISITS (PAST & PRESENT) FOR THIS INJURY _____

DATE EMPLOYEE TO RETURN FOR NEXT VISIT _____

DOCTOR'S
 NAME _____
 ADDRESS _____

 TELEPHONE # _____
 SIGNATURE _____
 DATE _____

*****AFFIX DOCTOR'S ADDRESS STAMP*****
REQUIRED