GREAT NECK PUBLIC SCHOOLS

EMPLOYEE ACCIDENT REPORT

EMPLOYEE NAME ______________________ SCHOOL/BUILDING ______________________

HOME ADDRESS ____

CITY ZIP CODE

PHONE # ______________________ ______________________ M / F

JOB TITLE MALE/FEMALE

___/___/ 20___ ________ AM PM ________ AM PM ______________________

DATE OF ACCIDENT TIME OF ACCIDENT EMPLOYEE START TIME PLACE/ROOM WHERE ACCIDENT OCCURRED

______________________ ___/___/ 20___ ___/___/ 20___

SUPERVISOR NAME DATE INFORMED OF **INJURY** DATE INFORMED OF **DISABILITY**

NATURE OF INJURY (BRUISED, BLEEDING, STRAINS) ______________________

PART OF BODY INJURED (INCLUDE RIGHT OR LEFT SIDE) ______________________

CAUSE OF INJURY (MOTOR VEHICLE, MACHINE, INJURY BY LIFTING, ETC.) ______________________

HOW DID ACCIDENT OCCUR (i.e., employee tripped over a pipe and fell on the floor) ______________________

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NAME & TEL. # OF WITNESS(ES) ______________________

DID EMPLOYEE LEAVE WORK DUE TO ACCIDENT?__________ DATE EMPLOYEE RETURNED TO WORK__________

INITIAL TREATMENT
___ NO MEDICAL TREATMENT ___ MINOR ON-SITE TREATMENT BY EMPLOYER
___ DR. OFFICE VISIT ___ EMERGENCY EVALUATION ___ HOSPITALIZATION MORE THAN 24 HRS.

NAME & ADDRESS OF DOCTOR PROVIDING TREATMENT FOR THIS INJURY:

____

NAME AND ADDRESS OF YOUR EMPLOYER(S) OTHER THAN GREAT NECK PUBLIC SCHOOLS:

____

IF YOU ARE ABSENT FROM WORK THREE (3) CONSECUTIVE DAYS OR MORE DUE TO THIS ACCIDENT, YOU MUST SUBMIT A 'DOCTOR'S ACCIDENT UPDATE REPORT' TO THE *PAYROLL DEPT*. FOR CONTINUAL ABSENCES, THE REPORT MUST BE SUBMITTED BY EVERY 1ST AND 15TH OF EACH AND EVERY MONTH.

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. I acknowledge that it is a crime to make false statements on a government document, file a false instrument or steal government services. 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 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 FALSIFICATION.

EMPLOYEE SIGNATURE ______________________ DATE__________

REPORTED BY: ______________________ DATE__________

______________________ ______________________

BUILDING ADMINISTRATOR DATE ASST. SUPERINTENDENT FOR BUSINESS DATE

SUBMIT COMPLETED FORM TO THE OFFICE OF ASSISTANT SUPERINTENDENT FOR BUSINESS **WITHIN 5 DAYS OF ACCIDENT.**

3/1/19