

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 #	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 ____/____/____ <small>month / day / year</small>	Age	Occupation	Department		Work Location and Title	
Work Status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time		Hours per Day	# Days per week if part time		Immediate Supervisor	
Injured body part / areas <i>(indicate left or right if applicable)</i>			District building where accident occurred <i>(street, city, zip code)</i>			
Time of Day injury or accident occurred: ____:____ AM or ____:____ PM			Date employer advised: ____/____/____ <small>month / day / year</small>			
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:

_____ <i>Doctor's Name</i>	_____ <i>School Nurse's Name</i>	_____ <i>Emergency Room Location</i>
_____ <i>Doctor's Address</i>	_____ <i>School</i>	_____ <i>Hospital</i>

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 name and 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."



EMPLOYEE INJURY AND ILLNESS REPORT

School District

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 Don't Know

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 file an electronic injury report with the District's Workers' Compensation TPA-PMA Management Corp. and provide a hard copy to the employee's supervisor for follow up, documentation, and signature.*
- *Page 2 of this report needs to be completed by the employee's immediate supervisor.*
- *The original completed form must be sent to Risk Management, Central Office.*
- *The supervisor is to follow up on the recommended corrective actions.*

The Syracuse City School District hereby advises students, parents, employees, and the general public that it offers employment and educational opportunities, including vocational education, without regard to age, gender, race, color, religion, marital status, sexual preference, national origin or disability. Questions regarding this policy may be referred to the building principal or District Title IX and Section 504 Compliance Officer at (315) 435-4212.