DOLGEVILLE CENTRAL SCHOOL

EMPLOYEE ACCIDENT REPORT FOR WORKERS' COMPENSATION

*ALL FORMS MUST BE COMPLETED BY THE SCHOOL NURSE DURING SCHOOL HOURS

EMPLOYEE INFORMAT	ION						
Employee's Name:				Today's Date:	/	/	
Employee's phone #:	() -			D.O.B			
Employee Address:				SS#:	-	-	
				Position:			
				Job Requirements:			
Employee's Supervisor:							
EMPLOYEE INJURY							
			D	ate of Accident:	//	-	
Location Where Accident Occurred:			Ti	me of Accident:	:	am/pm	
Room # (If a	available):		_			-	
Nature of Injury: (laceration, burn, strain)				Did Employee Stop Work for the day? Y or N			
Part of body: (left arm, right foot head etc.)			(If	(If yes, remember to fill out Request for Leave Form)			
	,		_				
Cause of injury: (machine, door, injury by lifting, etc.)			w	Was Medical Care Provided at school? Yor N If yes, by who?			
			_	ii yes, by wilo:			
Accident/Injury Descrip	ntion:		W	'hen was treatment g	given? Date and	l Time	
Accident/injury Description.			_ "	/ / :am/pm			
				OUTCIDE TREAT	T. 45.1T.		
			_	OUTSIDE TREA	IMENI:		
			_	Name and Address	s of Doctor:		
			_				
Initial Treatment:	No medical treatment	Minor on site treatment	:				
ER Evaluation Hospitalized >24 hrs				Name and Address of Hospital:			
Are there any extenuat	Minor clinic/hospital treating circumstances that you		pensation	carrier should be awa	are of?		
If so, please explain:	,	believe the workers com	pensation	earrier should be and		_	
						-	
WITNESS INFORMATIO	DN:						
Any witnesses to the in	cident? Y or N						
If so, please list names and phone numbers:			_ w	itness statement fille	ed out:		
				Y or N			
				Y or N			
			_	Y or N Y or N			
				1 01 11			
Camera footage availab		iewed? Y or N	Ву	/ who?			
Camera time stamp/date/ca	amera #						
Staff filling out form(Print name):					Date:		
School Nurse Signature:					Date:		
Supervisor's Signature:					Date:		
COPY SENT TO:	EMPLOYEE	SUPERVISOR	NURSE	BUSINESS (OFFICE		