EMPLOYEES REPORT OF INJURY *I* ILLNESS EMPLOYER NAME

Kinderhook CSD
2910 Route 9
Valatie, NY 12184
518-758·7575

School code 61111 0
NY UI: 04-6286856

Please complete all sections and sign the bottom of page 3

Date of Injury 'Illness: _____/_____/_____ Date of this Report: _____/_____/_____

EMPLOYEES PERSONAL INFORMATION

1. Name:. _____ 2. Date of Birth ____/____/____

3. Mailing Address_____
Street address City State zip

4. Social Security: _____ 5. Phone Number: (__)_____ 6. Gender: ☐Male ☐Female

EMPLOYEES INJURY OR ILLNESS

1. Time of day employee began work on date of injury: _____ AM /.PM

2. Time of injury: _____AM/ PM

3. Has the employee given you notice of injury illness? ☐Yes ☐ No

If yes, notice was given to:_____ ☐Orally ☐ In Writing
Date notice was given: ___/___/____

4. Where did the injury/illness happen?(e.g. 1 Main Street, Pottersville, at the front door):
_____

5. Was this the location where the employee normally works? ☐Yes ☐No If no, why was the employee there? _____

6. Name of employee's supervisor: _____ Work phone number_____

7. Did supervisor see injury happen? ☐Yes ☐No ☐Unknown

8. Did anyone else see the injury happen? ☐Yes☐ No ☐Unknown

If yes, give names: _____

EMPLOYEES NAME_____ DATE OF ILLNES INJURY: ____/____/____

9. What was the employee doing when he/she was injured or became ill? (i.e., unloading truck, typing annual report) _____
_____

10. How did the injury/illness occur? (e.g. the employee slipped in water and fell to the floor)
_____

11. Explain fully the nature of the employee's injury/illness; list body parts affected (e.g. twisted left ankle, cut to forehead): _____
_____

12. Was an object (e.g. forklift, hammer, acid) involved in the injury/illness? ☐Yes ☐No If yes, what?_____

13. Was the injury the result of the use or operation of a licensed motor vehicle? ☐Yes ☐ No

If yes ☐Employee's vehicle ☐Employer's vehicle ☐Other vehicle License plate number, if known:_____

If employers vehicle was involved, give the name and address of your motor vehicle insurance carrier:_____

14. Did the injurylillness result in the employee's death? ☐Yes ☐No
If yes, date of death? __/__/___ Name and address of nearest relative: _____

<u>MEDICAL TREATMENT</u> (attach any necessary paperwork from Dr. or clinic)

1. What was the date of the employee's first treatment? ____/____/_____
   ☐None received ☐ Unknown

2. Where did the employee receive first medical treatment for this injury/illness?

   ☐Onsite ☐Doctor's office ☐Emergency Room ☐Clinic/Hospital/Urgent Care
   ☐Hospital Stay over 24 hours ☐Unknown

Who treated the employee and where? _____

3. Is the employee still being treated for this injury / illness? ☐Yes ☐No ☐Unknown If yes, name and address of treating doctor(s):_____

4. To your knowledge, did the employee have another work related injury to the same body part or a similar illness while working for you? ☐Yes ☐No If yes, name the doctor(s) who treated the previous injuries/illnesses (if known):
_____
_____

EMPLOYEES NAME_____ DATE OF ILLNES IINJURY: ____/____/____

RETURN TO WORK

1. Did the employee stop work because of his/her injury/illness? ☐Yes ☐No If yes, on what date? ____/____/____

2. Has the employee returned to work? ☐Yes ☐No If yes, on what date? ____/____/____

3. If the employee has returned to work, limited or full duty? _____.

EMPLOYEES WORK INFORMATION on the date of the injury or illness

1. Date the employee was hired: ____/____/_____

2. What was the employee's job title? _____

3. What types of activities did the employee normally perform at work? _____
_____

EMPLOYEES PAYROLL INFORMATION on the date of the injury or illness

1. Employees gross pay in an average week was: $_____

2. Did the employee receive lodging or tips in addition to pay? ☐Yes ☐No If yes, describe:
_____

3. Employee's job was (check one): ☐Full Time ☐ Part Time ☐Seasonal ☐Volunteer
☐Other _____

4. Which days of the week did the employee usually work?
☐Monday ☐ Tuesday ☐Wednesday ☐Thursday ☐ Friday ☐ Saturday ☐ Sunday

5. Was the employee paid for a full day on the day of the injury/illness? ☐Yes ☐ No

6. Did you continue to pay the employee after the injury/illness (sick leave, vacation, disability, regular salary)? ☐ Yes ☐ No

ADDITIONAL INFORMATION:_____
_____
_____
_____

Signature of Employee_____ Date: ____/____/____

Signature of Principal/Supervisor_____
Date: ____/____/____