

EMPLOYEES REPORT OF INJURY / 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 injury/illness result in the employee's death? Yes No
If yes, date of death? ___/___/___ Name and address of nearest relative: _____

MEDICAL TREATMENT (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: ____/____/____