Ithaca
CITY SCHOOL DISTRICT

THIS FORM MUST BE RECEIVED IN THE HR OFFICE WITHIN 5 DAYS OF THE INCIDENT!

EMPLOYEE INCIDENT/ACCIDENT REPORT FORM

(Please Print)

Today's date:	**Date of Incident/Accident**:	**Date Employee Benefits Manager Received**:

BASIC INFORMATION

Employee last name: First: Middle:		❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Phone Number: ( ) -	
Time Work Day Began: ❑ AM ❑ PM	Date of Hire: / /	Birth date: / /	Gender: ☐ M ☐ F
Street Address:	Social Security No.: XXX – XX -_____	Job Title:	
P.O. Box:	City:	State:	ZIP Code:
Whom did you report the Incident/Accident to?	Date and time you reported it:	Did you receive an Injury Envelope? ❑ Yes ❑ No	If no, why?

CLAIM INFORMATION

Date of Incident/Accident: / /	Time of Incident/Accident: __:___ ❑ AM ❑ PM	
Employment Status: ❑ Full-Time ❑ Part-Time	❑ 10-12 month ❑ Other	❑ Standard Work Week ❑ Fixed Work Week ❑ Varied Work Week

Work Days Scheduled: ❑ Sun ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat

EMPLOYEE INJURY

Initial Treatment: ❑ No Medical Treatment ❑ Emergency Evaluation	❑ Minor On-Site Treatment By Employer ❑ Hospitalization Greater Than 24 Hours	❑ Minor Clinic/Hospital Treatment ❑ Future Major Medical/Lost Time Anticipated
Did ICSD provide any medical treatment? ❑ Yes ❑ No		Date/Time:
Name of person providing treatment:		
Did you seek medical Treatment elsewhere? ❑ Yes ❑ No		Date/Time:
Treatment/Facility Name:		Treatment/Facility Address:

***** IMPORTANT *****

All Medical Correspondence Must Be Submitted Straightaway to Your Supervisor or Human Resources Representative

Have you had a previous work-related injury to the same body part? ❑ Yes ❑ No If Yes, When? _____

***This Section Must Be completed. Please be detailed in your description of what happened.

Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc.):

Part of Body (i.e. left arm, right foot, head, multiple, etc.):

Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc.):

Incident/Accident Description:

LOCATION AND WITNESSES

Location Where Incident Occurred:

Is this your normal work Location? ❑ Yes ❑ No

Witnesses Name:	Witnesses Name:

Was there a delay between the time of the incident/accident and the time of this report? ❑ Yes ❑ No If Yes, explain why:

SUPERVISOR COMPLETE			
Did the employee complete the shift? ❑ Yes ❑ No		Did you release the employee to leave early? ❑ Yes ❑ No	
Did you remind employee to follow-up with you the next business day? ❑ Yes ❑ No			
Was employee provided with an Injury Envelope? ❑ Yes ❑ No If no, why?			
What needs to change in order for this type of incident/accident not to reoccur?			
1.			
2.			
3.			
Was a Work Order necessary? ❑ Yes ❑ No		Date Work Order sent to Maintenance:	
Supervisor Signature:		***Date:***	
FOLLOW-UP			
Actions taken on recommendations as outlined in by what needs to change?			
1.	Date Completed:	By:	Dept./Title:
2.	Date Completed:	By:	Dept./Title:
3.	Date Completed:	By:	Dept./Title:

☐ Check this box if you, the employee, independently and voluntarily request that your name NOT be entered on the OSHA Form SH-900 and you meet one or more of the qualifiers below (NYS DOL Log of Work Related Injuries and Illnesses). If checked, treat as a privacy concern case.

The employer must consider the following injuries/illnesses to be privacy concern cases:

1. An injury/illness to an intimate body part of the reproductive system; 2.
2. An injury/illness resulting from a sexual assault;
3. Mental illnesses
4. HIV infection, hepatitis, or tuberculosis;
5. Needle stick injuries and cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material;
6. Other illnesses, if the employee independently and voluntarily request that his or her name not be entered on the log. Effective January 1, 2004; Musculoskeletal disorders (MSD's) are not considered privacy concern cases.

This is a complete list of all injuries/illnesses considered privacy concern cases. No other types of injuries/illnesses may be classified as privacy concern cases.

By signing below, I verify that the information provided in the report is true, complete and accurate to the best of my knowledge. I understand that any willful omission of &/or falsification is fraudulent and may be punishable to the fullest extent under Section 114a of the NYS Workers Compensation Law. Furthermore, I also understand that completion of this document does not imply or guarantee acceptance of this claim by my employer or insurance carrier.

Employee Signature:_____ **Date:** __/__/__

Supervisor Signature:_____ **Date:** __/__/__

Office Use Only:_____Case number from the SH-900 Log:_____.
(Transfer the case number from the Sh-900 log after you record the case.)

**** Due to strict Workers Compensation Guidelines, this form must be forwarded A.S.A.P. to: Marta Costa-Potter ICSD Business Office****