WYANDANCH U.F.S.D. EMPLOYEE ACCIDENT REPORT

(7-1-2021)

EMPLOYEE'S STATEMENT:

Date of Accident: _____ **Employee's Work Location/ School:** _____ **Soc. Security Number: XXX-XX-**_____

Last Name: _____ **First Name:** _____ **MI:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____**Work Status: (PT/FT)** _____

Hours Worked Per Day: _____ **Days Worked Per Week:** _____ **Date of Hire:** _____**Job Title:**_____

Time began work on date of incident: _____ **Time of incident:** _____ **Time notified Supervisor:** _____

Exact location of incident: _____ **Witness Name(s):** _____

Describe how and why the accident occurred: _____

_____

_____

Indicate ALL body parts injured: _____

Indicate the *nature* of the injury: _____

Is this a reoccurrence of a previous injury? Yes ___ No ___ If Yes, provide details: _____

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

The above information is true to the best of my knowledge and belief:

Employee's Signature: _____ **Date:** _____

NURSE'S STATEMENT:

Was Medical Treatment Provided By School Nurse?: Yes ____ No ____ If yes, please describe the treatment and injury: _____

_____

_____

Name of Hospital or Physician Treating Employee: _____ **Date of Treatment:** _____

Was an EMT or Ambulance Service Used? Yes ____ No _____

Nurses Signature: _____ **Date:** _____

SUPERVISOR'S / PRINCIPAL'S STATEMENT:

Do you confirm that this accident has been reported to you? Yes ____ No _____ Date Accident Reported to you_____

Was the accident site or incident investigated? If so, please describe in detail: _____

_____

_____

If a witness was listed, did you include their statement? _____

Has Employee Continued To Work? Yes _____ No _____ If No, First Date of Lost Time: _____

Signature of Supervisor/Principal/Superintendent: _____ **Date Signed:** _____

EFFECTIVE 7/1/2021, Workers' Comp. Insurance Carrier: PERMA

9 Cornell Road, Latham, NY 12110 TEL: (888-737-6269) FAX: (877-737-6232)

Procedures for completing the EMPLOYEE ACCIDENT AND INJURY REPORT

1. Complete all the employee's information at the top of the form. It is important to include the employee's home and work phone numbers so PERMA may contact the employee regarding the accident.

2. Have the employee complete the EMPLOYEE'S STATEMENT section of the form describing the accident in detail. Make sure the employee signs and dates this section.

3. Have the employee's immediate supervisor complete the SUPERVISOR'S STATEMENT section of the form. It is important that the supervisor includes the date the accident was reported to him by the employee as well as any other details of the accident which was not included in the Employee's Statement.

4. If a witness was listed by the employee, please provide a statement from the witness.

5. If the employee was treated by the school nurse, please have the nurse describe the type of treatment provided and nature of injury.

6. If the accident was an emergency and the employee was taken to the hospital, the supervisor should immediately notify the Personnel Department so they can contact PERMA. This will allow for the expediting of treatment to the injured employee.

7. The completed form should be immediately sent to the Personnel Department *within 24 hours from the incident* so the Employee's claim can be properly managed. Failure to complete this form in a timely manner may delay treatment and prolong benefits.