RYE CITY SCHOOL DISTRICT

EMPLOYEE WORK-RELATED INCIDENT/INJURY/OCCUPATIONAL DISEASE REPORT

Employee Information:

First Name: _____ Last Name: _____ Date: _____

Home Address: _____ City: _____ Zip: _____

Personal Phone: _____ Work Phone: _____

Soc Sec#: _____ Sex: ☐ Male ☐ Female DOB: _____ Age: _____

Date of Hire: _____ Occupation: _____ ☐ Full Time ☐ Part Time

# of days in work week: _____ Normal hours of employment: Start ____:____ ☐am ☐pm End ____:_____ ☐am ☐pm

Incident Information:

Date of Incident: _____ Time of Incident: ____:_____ ☐am ☐pm

Building name and address of location where incident occurred, Name: _____

Address: _____ City: _____ Zip: _____

Specific location (ex. First floor hallway, Classroom 201, Steps main entrance): _____

Detailed description of how incident occurred: _____

_____

_____

_____

Were you injured or become ill: ☐ Yes ☐ No If yes, did you require medical treatment: ☐ Yes ☐ No

If yes, list names and addresses of all medical facilities and providers (visited or plan to visit): _____

_____

Did you lose any time from work: ☐ Yes ☐ No ☐ Unknown at this time If yes, list dates:_____

Did you notify a Supervisor: ☐ Yes ☐ No

If yes, Name of Supervisor: _____ Date: _____Time: ____:_____ ☐am ☐pm

Detailed description and nature of injury or illness (Right wrist, Left thumb, Lower back etc.): _____

_____

_____

List all Witnesses: _____

I, _____ herein certify that the information above is true and to the best of my knowledge.
(Print employee/your name above)

Employee Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____ Business Official: _____ Date: _____