GREAT NECK PUBLIC SCHOOLS
EMPLOYEE INCIDENT REPORT

EMPLOYEE NAME _____ SCHOOL/BUILDING _____

HOME ADDRESS _____

CITY ZIP CODE

PHONE # _____ _____ M / F

JOB TITLE MALE/FEMALE

AM AM

__/__/__ _____ PM _____ PM _____

DATE OF INCIDENT TIME OF INCIDENT EMPLOYEE START TIME PLACE/ROOM WHERE INCIDENT OCCURRED

_____ __/__/__ __/__/__

SUPERVISOR NAME DATE INFORMED OF **INCIDENT** DATE INFORMED OF **DISABILITY**

INITIAL TREATMENT ___ NO MEDICAL TREATMENT ___ MINOR ON-SITE TREATMENT BY EMPLOYER
___ DR. OFFICE VISIT ___ EMERGENCY EVALUATION ___ HOSPITALIZATION MORE THAN 24 HRS.

DID EMPLOYEE LEAVE WORK DUE TO INCIDENT? _____ DATE EMPLOYEE RETURNED TO WORK _____

NATURE OF INJURY (BRUISED, BLEEDING, STRAINS) _____

PART OF BODY INJURED (INCLUDE RIGHT OR LEFT SIDE) _____

CAUSE OF INJURY (MOTOR VEHICLE, MACHINE, INJURY BY LIFTING, ETC.) _____

HOW DID INCIDENT OCCUR (i.e., employee tripped over a pipe and fell on the floor) _____

_____

_____

NAME & TEL. # OF WITNESS(ES) _____

NAME AND ADDRESS OF YOUR EMPLOYER(S) OTHER THAN GREAT NECK PUBLIC SCHOOLS:

_____

IF YOU ARE ABSENT FROM WORK THREE (3) CONSECUTIVE DAYS OR MORE DUE TO THIS INCIDENT, YOU MUST SUBMIT A 'DOCTOR'S INCIDENT UPDATE REPORT'. FOR EXTENDED ABSENCES, THE REPORT MUST BE SUBMITTED BY EVERY 1ST AND 15TH OF EACH AND EVERY MONTH.

Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or self-insurer, any information containing any false material statement or conceals any material fact, shall be guilty of a crime and subject to substantial fines and imprisonment. I acknowledge that it is a crime to make false statements on a government document, file a false instrument or steal government services. By signing this report, I confirm that all information submitted is true and accurate to the best of my knowledge and belief.

I ACKNOWLEDGE THAT THE DISTRICT RESERVES THE RIGHT TO TERMINATE EMPLOYMENT, INITIATE CIVIL OR CRIMINAL ACTION, INCLUDING BUT NOT LIMITED TO FRAUD AND/OR PERJURY, IN THE EVENT OF FALSIFICATION.

EMPLOYEE SIGNATURE _____ DATE _____

REPORTED BY: _____ DATE _____

SUBMIT COMPLETED FORM TO THE OFFICE OF DEPUTY SUPERINTENDENT **WITHIN 5 DAYS OF INCIDENT**

PRINT NAME: _____

_____ _____

ADMINISTRATOR DATE DEPUTY SUPERINTENDENT DATE