REMSEN CENTRAL SCHOOL DISTRICT

REMSEN, NEW YORK 13438

SUPERVISOR ACCIDENT REPORT

Was accident on employer's premises? ☐ Yes ☐ No Last day of work: _____

Date supervisor was first notified of injury: _____

Was employee paid in full for day? ☐ Yes ☐ No Has employee returned to work? ☐ Yes ☐ No

- If yes, date returned to work: _____

Fatal Cases: Date of death: _____

Name/Address of nearest relative: _____

Relationship to deceased: _____

_____ _____

Signature of Employee *Signature of Person Completing Report*

Date of this report: _____

IF LOSS OF WORK, TIME OR MEDICAL BILLS HAS BEEN INCURRED, COMPLETE THE FOLLOWING:

Supervisor's Investigation:_____

_____

_____

_____

DID EMPLOYEE SIGN THE MEDICAL/WAGE CONSENT FORM? ☐ Yes ☐ No

_____ _____

Signature of Supervisor *Date*

Witness of injury (state exactly what you saw): _____

_____

_____

_____

_____ _____

Signature of Witness *Date*

copy: Office file

REMSEN CENTRAL SCHOOL DISTRICT

REMSEN, NEW YORK 13438

EMPLOYEE ACCIDENT REPORT

Name: _____ SS #:_____
(First) (M.I.) (Last)

Home Address: _____
(Street) (State) (Zip)

Mailing Address (if different than above): _____

Phone #: _____ D.O.B.: _____ Gender: _____ Occupation: _____

Department in which employed: _____ Employed: ☐ Part-Time ☐ Full-Time

Days of week usually worked: _____

Accident occurred: Date: _____ Time: _____ ☐ AM ☐ PM

Location: _____ Location address: _____

Nature of injury/part of body involved: _____

_____

_____

Medical care provided? ☐ Yes ☐ No If yes, when? _____

If being treated: Name/address of doctor: _____

Name/address of hospital: _____

What was employee doing when injured? _____

_____

How did the accident occur? _____

_____

Object/substance that directly injured employee? _____

_____

Other employment: _____

_____ _____
Employee's Signature *Date*

copy: Office file

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REMSEN, NEW YORK 13438

CONSENT TO DEVELOP MEDICAL AND WAGE INFORMATION

"I hereby consent and request that the bearer be permitted to examine and obtain copies of all hospital and medical records of every sort and kind, interview doctors and other attendants regarding all matters relating to examination, diagnosis, care and treatment of myself. I further consent and request that the bearer be permitted to interview and correspond with all employers and former employers regarding all matters relating to my earnings and loss of earnings."

"I also hereby consent that a photostatic copy of this authorization be accepted with the same authority as the original."

_____ _____
Signature of Employee *Date*

_____
Street Address *City* *State* *Zip*

copy: Office file