



GREAT NECK PUBLIC SCHOOLS EMPLOYEE INCIDENT REPORT

EMPLOYEE NAME _____ SCHOOL/BUILDING _____

HOME ADDRESS _____

CITY _____ ZIP CODE _____

PHONE # _____ M / F _____

JOB TITLE _____ MALE/FEMALE _____

_____/_____/_____ AM PM AM 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 _____