For Office Use Only:
Hire Date ______________
Daily Rate ______________

Worker's Compensation Accident/Injury Report

▲ Name (Include First, MI and Last)

▲ Mailing Address (include No. & Street, Apt. No.)

▲ Social Security No

▲ Date of Birth

▲ Mailing Address (include City, Zip)

▲ Telephone #

▲ Job Title

▲ Division/Department/Location

▲ Work Week (Indicate days of week usually worked)

ACCIDENT

Date of Accident: __________ Time of Accident: _________ Location where accident occurred: ______________________

Witness(es) if any: ____

Did you stop work because of this injury? ❒ No ❒ Yes If yes, date: ____

NATURE OF INJURY

Description of Injury (state fully the nature of your injury including all parts of the body affected):

Did employee receive medical care other than school nurse? ❒ No ❒ Yes If yes, contact Patti Sherlock at (315) 431-8570 for additional paperwork.

If medical care was received, from whom and date (check box below):

❒ School Nurse

▲ Name ▲ Date

❒ Physician

▲ Name ▲ Date

▲ Address

❒ Hospital/ Emergency Facility

▲ Name ▲ Date

▲ Address

Has employee returned to work? ❒ No ❒ Yes If yes, date: ____

CAUSE OF ACCIDENT

How did the injury occur (describe fully, state what happened and how it happened) Use separate sheet if necessary:

What was the employee doing at the time of the accident (be specific, identify tools, euipment or materials the employee was using):

Object/substance that directly injured this employee:

▲ Signature of Injured Person ▲ Date

▲ Supervisor's Signature ▲ Date

Submit completed report to OCM BOCES Personnel Office

Rev: 1/14/08