

**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: \_\_\_\_\_