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| WORKERS' COMP CARRIER: NCACOMP, INC 14 LAFAYETTE SQUARE SUITE 700 BUFFALO, NY 14203 | | CORTLAND ENLARGED CITY SCHOOL DISTRICT EMPLOYEE ACCIDENT AND ILLNESS REPORT | | | EMPLOYEE'S PHONE: | |
| *** ALL PARTS MUST BE COMPLETED NEATLY AND IN FULL *** | | | | | | |
| SOC. SECURITY NO. | | NAME: (LAST) (FIRST) (MI) | | | GENDER: M, F, OR OTHER | |
| HOME ADDRESS | | CITY | | STATE | ZIP | DATE OF BIRTH: |
| JOB TITLE | | WORK STATUS (CIRCLE) PART FULL | | DATE OF HIRE: | | DATE AND TIME OF INJURY: AM or PM |
| NAME OF SCHOOL | | | | NAME OF IMMEDIATE SUPERVISOR | | |
| EMPLOYEE'S STATEMENT - FULLY EXPLAIN THE NATURE OF THE INJURY/ILLNESS (HOW AND WHY ACCIDENT OCCURRED; ALL BODY PARTS INJURED; WAS AN OBJECT INVOLVED) | | | | | | |
| Body Parts injured (please note left or right if appropriate): | | | | | | |
| Detail of what happened: | | | | | | |
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| Do you remember having another injury to the same body part or a similar illness? Yes No If yes, were you treated by a doctor? Yes No If yes, provide the names and addresses of the doctor(s) who treated you: | | | | | | |
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| LOCATION ADDRESS | | | | | DATE SUPERVISOR WAS NOTIFIED | |
| IF THIS IS A RECURRENCE OF A PREVIOUS INJURY OR ILLNESS? YES NO | | | | IF "YES" GIVE DETAILS: | | |
| HOW COULD THE INJURY HAVE BEEN PREVENTED? | | | | | | |
| NAME OF WITNESS: | | | | NAME OF WITNESS: | | |
| WAS MEDICAL TREATMENT PROVIDED TO EMPLOYEE: YES NO IF "YES" LIST MEDICAL FACILITY, ADDRESS, AND DATE OF FIRST TREATMENT NAME OF MEDICAL FACILITY: | | | | | | |
| ADDRESS: | | | | DATE OF FIRST TREATMENT: | | |
| ANY EMT OR AMBULANCE SERVICE USED? YES NO | | | | | | |
| DID THE EMPLOYEE STOP WORK BECAUSE OF THIS INJURY/ILLNESS? YES NO | | | | | IF "YES" FIRST DATE OF LOST TIME: | |
| HAS THE EMPLOYEE RETURNED TO WORK? YES NO | | | | | IF "YES" ON WHAT DATE: | |
| SIGNATURE OF NURSE: | | | | DATE: | | |
| SUPERVISOR'S STATEMENT DO YOU CONFIRM THIS INJURY OR ILLNESS? YES NO HOW COULD THE INJURY HAVE BEEN PREVENTED? | | | | | | |
| CERTIFICATION: I CERTIFY THAT THIS ACCIDENT/INJURY REPORT IS COMPLETE AND ACCURATE, FALSE REPRESENTATIONS COULD RESULT IN CIVIL AND CRIMINAL PENALTIES. | | | | | | |
| SIGNATURE OF EMPLOYEE: | | | | DATE: | | |
| THIS REPORT IS BASED ON INFORMATION PROVIDED BY THE ABOVE EMPLOYEE: | | | | | | |
| SIGNATURE OF SUPERVISOR: | | | | DATE: | | |
| PERSONNEL OFFICE RECEIVED | | | | | | |
| SIGNATURE OF SAFETY OFFICER: | | | | DATE: | | |