

*Submit to District Office Within 3 days of accident*  
**SOLVAY UNION FREE SCHOOL DISTRICT**  
**EMPLOYEE ACCIDENT REPORT**

EMPLOYEE NAME \_\_\_\_\_  MALE  FEMALE

ADDRESS \_\_\_\_\_ CITY/ZIP \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

POSITION \_\_\_\_\_ SCHOOL \_\_\_\_\_ DATE HIRED \_\_\_\_\_

DATE OF ACCIDENT \_\_\_\_\_ TIME OF ACCIDENT \_\_\_\_\_ TIME EMPLOYEE BEGAN WORK \_\_\_\_\_

TIME LOST FROM WORK (dates, if applicable) \_\_\_\_\_

DESCRIPTION OF ACCIDENT (what were you doing, what caused the accident): \_\_\_\_\_

\_\_\_\_\_

NATURE OF INJURY (part(s) of body affected and how affected): \_\_\_\_\_

WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE? \_\_\_\_\_

WAS MEDICAL CARE PROVIDED?  YES  NO IF YES, WHEN & BY WHOM? \_\_\_\_\_

WITNESS(ES) \_\_\_\_\_

TREATED IN AN EMERGENCY ROOM?  YES  NO HOSPITALIZED OVERNIGHT (Inpatient)?  YES  NO

**DATE OF FIRST VISIT TO PHYSICIAN/HOSPITAL FOR THIS INJURY (if applicable)** \_\_\_\_\_

**PLEASE INFORM Annette Conklin in the District Office if you see a physician after submitting this form.**

NAME & ADDRESS OF PHYSICIAN:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NAME & ADDRESS OF HOSPITAL:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE RETURNED TO WORK \_\_\_\_\_

EMPLOYEE'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SUPERVISOR'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**DATE SUPERVISOR FIRST KNEW OF INJURY** \_\_\_\_\_

IF EMPLOYEE DIED, WHEN DID DEATH OCCUR? \_\_\_\_\_

**PLEASE NOTE:** If the above incident is a result of an illness related workers comp claim and **not an accidental injury**, please complete the following:

**ILLNESS RELATED WORKERS COMP CASES ONLY:** Please sign on the line below if you independently and voluntarily request that your name not be entered on the "Log of Work Related Illnesses." Please note this **does not pertain to accidental injuries**.

**Please note:** When an employee is injured while on duty and requires medical attention from a physician or hospital, please inform the physician/hospital that our insurance carrier is: NCA Comp, 14 Lafayette Sq., Suite 700, Buffalo, NY 14203, phone 1-888-806-1109.

***PLEASE FORWARD ORIGINAL TO THE DISTRICT OFFICE WITHIN 3 DAYS OF INCIDENT TO THE ATTENTION OF Annette Conklin.***