## Lansing Central School District

# employee incident/accident report form

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| (Please Print) |
| Today’s date: | Date of Incident/Accident: | Date Human Resources Received: |
| basic information |
| Employee last name: | First: | Middle: | ❑ Mr.❑ Mrs. | ❑ Miss❑ Ms. | Phone Number: |
|  | ( ) - |
| Time Work Day Began: ❑ AM ❑ PM | Date of Hire: / / | Birth date: / / | Gender:  M  F |
| Street Address: | Social Security No.: | Job Title: |
|  | XXX – XX -\_\_\_\_\_\_\_\_ |  |
| P.O. Box: | City: | State: | ZIP Code: |
|  |  |  |  |
| Whom did you report the Incident/Accident to? | Date and time you reported it: | Did you receive an Injury Envelope? |
|  |  | ❑ Yes ❑ No |  If no, why?  |
| claim INFORMATION |
| Date of Incident/Accident: / / | Time of Incident/Accident: ❑ AM ❑ PM |
| Employment Status: | Primary Position is: | Work Week Type:  |
| ❑ Full-Time ❑ Part-Time  | ❑ 10-12 month ❑ Other  | ❑ Standard Work Week ❑ Fixed Work Week ❑ Varied Work Week |
| Work Days Scheduled: | ❑ Sun | ❑ Mon | ❑ Tues | ❑ Wed  | ❑ Thurs | ❑ Fri | ❑ Sat |
| Employee Injury |
| Initial Treatment: ❑ No Medical Treatment | ❑ Minor On-Site Treatment By Employer | ❑ Minor Clinic/Hospital Treatment |
|  ❑ Emergency Evaluation | ❑ Hospitalization Greater Than 24 Hours | ❑ Future Major Medical/Lost Time Anticipated |
| Did ***LANSING SCHOOL*** provide any medical treatment? ❑ Yes ❑ No | Date/Time: |
| Name of person providing treatment: |  |
| Did you seek medical Treatment elsewhere? ❑ Yes ❑ No | Date/Time: |
| Treatment/Facility Name: | Treatment/Facility Address: |
| ***\*\* IMPORTANT \*\*******All Medical Correspondence Must Be Submitted Straightaway to: [Employee Benefits Person Here]*** |
| Have you had a previous work-related injury to the same body part? ❑ Yes ❑ No If Yes, When?  |
| Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc.): |
| Part of Body (i.e. left arm, right foot, head, multiple, etc.): |
| Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc.): |
| Incident/Accident Description: |
|  |
|  |
| Location and Witnesses |
| Location Where Incident Occurred: |
| Is this your normal work Location? ❑ Yes ❑ No |
| Witnesses Name: | Witnesses Name: |
| Was there a delay between the time of the incident/accident and the time of this report? ❑ Yes ❑ No If Yes, explain why: |
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| SUPERVISOR COMPLETE |

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| Did the employee complete the shift? ❑ Yes ❑ No | Did you release the employee to leave early? ❑ Yes ❑ No |

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| Did you remind employee to follow-up with you the next business day? ❑ Yes ❑ No  |
| Was employee provided with an Injury Envelope? ❑ Yes ❑ No If no, why? |
| What needs to change in order for this type of incident/accident not to reoccur? |
| 1. |
| 2. |
| 3. |
| Was a Work Order necessary? ❑ Yes ❑ No | Date Work Order sent to Maintenance: |
| **Supervisor Signature:** | **Date:** |
| follow-up |
| Actions taken on recommendations as outlined in by what needs to change? |
| 1. | Date Completed: | By: | Dept./Title: |
| 2. | Date Completed: | By: | Dept./Title: |
| 3. | Date Completed: | By: | Dept./Title: |

☐ Check this box if you, the employee, independently and voluntarily request that your name NOT be entered on the OSHA Form SH-900 and you meet one or more of the qualifiers below (NYS DOL Log of Work Related Injuries and Illnesses). If checked, treat as a privacy concern case.

The employer must consider the following injuries/illnesses to be privacy concern cases:

1. An injury/illness to an intimate body part of the reproductive system; 2.
2. An injury/illness resulting from a sexual assault;
3. Mental illnesses
4. HIV infection, hepatitis, or tuberculosis;
5. Needle stick injuries and cuts from sharp objects that are contaminated with another person’s blood or other potentially infectious material;
6. Other illnesses, if the employee independently and voluntarily request that his or her name not be entered on the log. Effective January 1, 2004; Musculoskeletal disorders (MSD’s) are not considered privacy concern cases.

This is a complete list of all injuries/illnesses considered privacy concern cases. No other types of injuries/illnesses may be classified as privacy concern cases.

*By signing below, I verify that the information provided in the report is true, complete and accurate to the best of my knowledge. I understand that any willful omission of &/or falsification is fraudulent and may be punishable to the fullest extent under Section 114a of the NYS Workers Compensation Law. Furthermore, I also understand that completion of this document does not imply or guarantee acceptance of this claim by my employer or insurance carrier.*

**Employee Signature: Date: / / \_\_**

**Supervisor Signature: Date: / / \_ \_\_**

Office Use Only: Case number from the SH-900 Log: .

(Transfer the case number from the Sh-900 log after you record the case.)

**\*\* Due to strict Workers Compensation Guidelines, this form must be forwarded A.S.A.P. to: LCSD Finance Clerk \*\***