NORTH SALEM CENTRAL SCHOOL DISTRICT

EMPLOYEE INCIDENT REPORT

NAME:	**DATE:**
ADDRESS:	**PHONE:**

SS#:	**AGE:**	**BIRTHDATE:**

OCCUPATION:	**DEPARTMENT WHERE REGULARLY EMPLOYED:**
DATE OF HIRE:	**Time Employee Began Work:**
DATE OF ACCIDENT:	**TIME OF ACCIDENT:** **AM or PM**
ADDRESS WHERE ACCIDENT OCCURRED?	**WAS ACCIDENT ON EMPLOYER'S PREMISES?**

NATURE OF INJURY AND PART (S) OF BODY AFFECTED:

WHAT WAS EMPLOYEE DOING WHEN INJURED?

HOW DID THE ACCIDENT OR EXPOSURE OCCUR?

NAME (S) OF ANY WITNESS: _____

_____

WAS FIRST AID RENDERED? **IF YES BY WHOM:**

☐ **YES** ☐ **NO**

DESCRIBE FIRST AID:

NAME AND ADDRESS OF HOSPITAL:

WAS A FOLLOW–UP BY A PHYSICIAN NECESSARY? ☐ **YES** ☐ **NO**	**IF YES, PHYSICIAN NAME AND ADDRESS:**

HAS EMPLOYEE RETURNED TO WORK? **IF YES, DATE RETURNED TO WORK:**

☐ **YES** ☐ **NO**

DATE SUPERVISOR FIRST KNEW OF INJURY:

SUPERVISOR SIGNATURE:	**DATE:**
BUILDING NURSE SIGNATURE (if applicable):	**DATE:**
EMPLOYEE SIGNATURE:	**DATE:**

ALL INJURIES THAT OCCUR WHILE WORKING MUST BE REPORTED TO YOUR SUPERVISOR

WHEN EVER POSSIBLE PLEASE SEE THE SCHOOL NURSE

AFTER SUPERVISOR SIGNS~RETURN COMPLETED FORM TO THE BUSINESS OFFICE

THANK YOU