GREAT NECK UNION FREE SCHOOL DISTRICT
345 LAKEVILLE ROAD
GREAT NECK, NY 11020

D O C T O R ' S A C C I D E N T U P D A T E R E P O R T

Download additional forms at GNPS homepage/forms/payroll/purchasing

*****IMPORTANT***** COMPLETED FORM MUST BE SUBMITTED TO *PAYROLL* AFTER 3 CONSECUTIVE DAYS OR MORE OF ABSENCES DUE TO INJURY. FOR CONTINUAL ABSENCES, SUBMIT FORM BY THE 1ST AND 15TH OF EACH AND EVERY MONTH WHILE YOU ARE OUT. FAILURE TO DO SO MAY RESULT IN DELAY OF PAYCHECK.

******PAYROLL FAX # 516-441-4925******

TO BE COMPLETED BY EMPLOYEE

DATE OF ACCIDENT_____

EMPLOYEE NAME_____ SCHOOL OR LOCATION_____

EMPLOYEE ADDRESS_____

HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO IF YES, DATE RETURNED_____

IF YOU HAVE NOT RETURNED, WHEN WAS YOUR LAST DAY WORKED?_____

Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or self-insurer, any information containing any false material statement or conceals any material fact, shall be guilty of a crime and subject to substantial fines and imprisonment. By signing this report, I confirm that all information submitted is true and accurate to the best of my knowledge and belief. I acknowledge that it is a crime to make false statements on a government document, file a false instrument or steal government services. The District reserves the right to terminate employment, initiate civil or criminal action, including but not limited to fraud and/or perjury, in the event of such falsification.

EMPLOYEE SIGNATURE_____DATE_____

TO BE COMPLETED BY DOCTOR

IS EMPLOYEE ABLE TO WORK? ☐ YES ☐ NO CAN EMPLOYEE WORK WITH MODIFIED DUTIES? ☐ YES ☐ NO

IF YES, PLEASE INDICATE RESTRICTIONS_____

_____

IF DISABLED (UNABLE TO WORK), PLEASE INCLUDE CLINICAL DIAGNOSIS AND DESCRIBE PRESENT CONDITION:

_____

_____

IF EMPLOYEE IS CONTINUOUSLY DISABLED (UNABLE TO WORK), PLEASE SUPPLY DATE DISABILITY BEGAN:

FROM_____TO_____

WHEN DO YOU ANTICIPATE EMPLOYEE CAN RETURN TO WORK?_____

LIST DATES OF VISITS (PAST & PRESENT) FOR THIS INJURY_____

DATE EMPLOYEE TO RETURN FOR NEXT VISIT_____

DOCTOR'S
NAME_____
ADDRESS_____
_____
TELEPHONE #_____

SIGNATURE_____
DATE_____

AFFIX DOCTOR'S ADDRESS STAMP
REQUIRED