



GREAT NECK PUBLIC SCHOOLS EMPLOYEE ACCIDENT REPORT

EMPLOYEE NAME _____ SCHOOL/BUILDING _____

HOME ADDRESS _____

CITY _____ ZIP CODE _____

PHONE # _____ M / F _____

JOB TITLE _____ MALE/FEMALE _____

_____/_____/20 AM PM AM PM

DATE OF ACCIDENT TIME OF ACCIDENT EMPLOYEE START TIME PLACE/ROOM WHERE ACCIDENT OCCURRED

_____/_____/20 _____/_____/20

SUPERVISOR NAME DATE INFORMED OF INJURY DATE INFORMED OF DISABILITY

NATURE OF INJURY (BRUISED, BLEEDING, STRAINS) _____

PART OF BODY INJURED (INCLUDE RIGHT OR LEFT SIDE) _____

CAUSE OF INJURY (MOTOR VEHICLE, MACHINE, INJURY BY LIFTING, ETC.) _____

HOW DID ACCIDENT OCCUR (i.e., employee tripped over a pipe and fell on the floor)

NAMES & TEL. # OF WITNESSES _____

DID EMPLOYEE LEAVE WORK DUE TO ACCIDENT? _____ DATE EMPLOYEE RETURNED TO WORK _____

INITIAL _____ NO MEDICAL TREATMENT _____ MINOR ON-SITE TREATMENT BY EMPLOYER
TREATMENT _____ DR. OFFICE VISIT _____ EMERGENCY EVALUATION _____ HOSPITALIZATION MORE THAN 24 HRS.

NAME & ADDRESS OF DR. _____

NAME AND ADDRESS OF YOUR EMPLOYER(S) OTHER THAN GREAT NECK PUBLIC SCHOOLS

IF YOU ARE ABSENT FROM WORK THREE (3) CONSECUTIVE DAYS OR MORE DUE TO THIS ACCIDENT, YOU MUST SUBMIT A 'DOCTOR'S ACCIDENT UPDATE REPORT' TO THE PAYROLL DEPT. FOR CONTINUAL ABSENCES, THE REPORT MUST BE SUBMITTED BY EVERY 1ST AND 15TH OF EACH AND EVERY MONTH.

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 _____

REPORTED BY: _____ DATE _____

BUILDING ADMINISTRATOR _____ DATE _____ ASST. SUPERINTENDENT FOR BUSINESS _____ DATE _____

SUBMIT COMPLETED FORM TO THE OFFICE OF ASSISTANT SUPERINTENDENT FOR BUSINESS **WITHIN 5 DAYS OF ACCIDENT**

C-3 Form

ALL ABSENCES RELATED TO THE ABOVE ACCIDENT TO BE CODED 'R'

HR