PLAINVIEW-OLD BETHPAGE CSD
Employee Accident Form

PLEASE PRINT

Sections I, II, and III of this report must be completed immediately after injury by the employee, a copy should be emailed to cportugal@pobschools.org and the original given to your Supervisor or School Nurse for approval.

If you did not suffer an injury and just want to document this incident, please email your supervisor. Do NOT use this form *

SECTION I: EMPLOYEE'S REPORT OF INJURY

Name:_____ S.S. No. _____

Address:_____ Phone No. _____

City/ State/ Zip:_____

Gender: ☐ M ☐ F Age: ____ Date of Birth: _____ Job Title: _____

SECTION II: DESCRIPTION OF INJURY

Date of Incident:_____ Time of Incident:_____☐ AM ☐ PM

Location of Incident: (Building/Room or Area): _____

Supervisor's Name:_____Hour you began work:_____☐ AM ☐ PM

Description of Incident: (State whether you slipped, fell, were struck, etc., and what you were doing (task) at time of injury): _____

_____

State nature of injury and parts of body affected (specify right or left, e.g., if arm, specify exact part of arm: elbow, shoulder, forearm, etc.): _____

_____

Names of Witnesses: _____

SECTION III: MEDICAL INFORMATION

Were you treated by the school nurse: ☐ Yes ☐ No Did you go to a doctor or hospital: ☐ Yes ☐ No

Hospital name and address: _____

Name and address of doctor: _____

Employee Signature:_____Date: _____

Principal/Supervisor Signature:_____Date: _____

Employee: You should not pay any medical providers directly for treatment of your work-related injury or illness. Remember to email a copy of this report to Carol Portugal from the Business Office cportugal@pobschools.org so she can file a claim for you. She will email your claim # within 24 hours.