## 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: | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| |  | | --- | | SUPERVISOR COMPLETE | | | | | | | | | | | | | | | | | | |
| |  |  | | --- | --- | | Did the employee complete the shift? ❑ Yes ❑ No | Did you release the employee to leave early? ❑ Yes ❑ No | | | | | | | | | | | | | | | | | | |
| 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 \*\***