WASHINGTON•SARATOGA
BOCES
BOARD OF COOPERATIVE EDUCATIONAL SERVICES
WARREN•HAMILTON•ESSEX

HR-E005

HUMAN RESOURCE SERVICES
1153 Burgoyne Avenue, Suite 2
Fort Edward, NY 12828-1134

EMPLOYEE INJURY / ILLNESS INCIDENT REPORT

Full Name: ____ Gender: ☐ Male ☐ Female

Home Address: ____ Phone # (___) __________
Street *City* *State* *Zip*

Job Title: ______________________________ Department: ______________ Date of Hire: __________

Worksite: ______________________________ Regular Work Hours: From: __________ To: __________

Date of Injury/ Illness: ____________________ Time of Occurrence: ____________ AM / PM *(Circle One)*

1. Nature of injury (must specify part of body injured, left or right side, upper, lower, etc.): ______________________________
____
2. What was employee doing when injured? (Please be specific, Identify tools, equipment or materials used) __________________
____
____
3. How did injury occur? ____
____
4. Object/Substance that directly injured employee: ______________________________
5. Was medical care provided? YES ☐ NO ☐ If YES, when: __________ By whom: ______________________
6. Did Employee Remain on Duty? YES ☐ NO ☐ If NO, what time did employee leave site? __________ AM / PM *(Circle One)*
7. Treatment provided by School Nurse (if applicable): ______________________________
____

Name/Address of Doctor: ____
Name/Address of Hospital: ____
8. Name of eyewitnesses with statements: ______________________________________
____

______________________________ ____________________
EMPLOYEE'S SIGNATURE DATE

______________________________ ____________________
SIGNATURE OF SCHOOL NURSE DATE

THIS SECTION MUST BE COMPLETED BY SUPERVISOR

Date employee stopped work: ________ Has employee returned to work? YES ☐ NO ☐ If YES, date of return: ________

Date supervisor first knew of injury: ____________________

______________________________ ____________________
SUPERVISOR'S SIGNATURE DATE

Supervisor please distribute:
1. Original to Human Resource Services – Benefits
2. Copy to be kept in Immediate Supervisor's file
3. Copy to the Health Office
4. Copy to Employee

Recordable: YES ☐ NO ☐ BY: ____________

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