OYSTER BAY-EAST NORWICH CENTRAL SCHOOL DISTRICT
OYSTER BAY, NEW YORK

COMPENSATION ACCIDENT REPORT

____/____/_____ Date of Report

____________________ Name of School

__________________FT/PT Position

Name of Injured____ M F

Home Address____
Street Town Zip

Date of Birth _____/_____/_______ Social Security Number ______/_____/______

Employee's daily hours _____- _____ Date of accident ___/____ Time ____am ____pm

Place of accident __________________Date reported _____/_____ Time ____am ____pm

Full description & specifics of accident/injury including body part & how it was affected.

____

____

____

____

First aid given ________________________________ by whom ___________________

Did you stop work because of this accident/injury? **Y N**

Did you go to emergency room? **Y N** Were you hospitalized? **Y N** How long? _______

Name and address of Hospital____

Name and address of Physician ____

Date employee returned to work ______/_____/______

Witnesses as reported by injured Address

1.__________________________ ______________________________________

2.__________________________ ______________________________________

__________________________ Supervisor/Principal's Signature

______________________________________ Signature of person making report

Revised 6/07 WHITE – ADMINISTRATION YELLOW – WRM PINK – INJURED PERSON