FRONTIER CENTRAL SCHOOL DISTRICT
EMPLOYEE ACCIDENT/INVESTIGATION REPORT

Incident Date _____ Time Occurred _____ Date Reported _____

Employee Name _____ Sex: M ☐ F ☐ D.O.B. _____

Address _____

E-mail Address _____ Home Phone # _____ Cell Phone # _____

SS # __xxx-xx-_____ Date of Hire _____ Full Time ☐ Part Time ☐ Substitute ☐

Days Worked ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ SU 10 month employee ☐ 12 month employee ☐

Time of Day Employee Began Work _____ Wages/Hour _____

Occupation _____ How Long Employed in Current Occupation _____

Job Location _____

Person Reported to _____ Orally ☐ In Writing ☐

Witness(es) _____

Location of Incident _____

Description of Incident _____

_____

Source of Injury (see back page) _____

Nature of Injury (see back page) _____

Body Part (s) Involved (specify right or left) _____

_____

Major Cause of Accident _____

Has it been Corrected Yes ☐ No ☐ If Yes, How: _____

If No, Why not?: _____

What steps have been taken to prevent similar incidents? _____

What steps should be taken to prevent a recurrence? _____

Any Property, Product, or Equipment Damage Yes ☐ No ☐ Motor Vehicle Accident? Yes ☐ No ☐

If Yes, Describe _____

Who Provided Medical Care? _____ When? _____

Doctor _____ Hospital _____

Ongoing treatment for Accident? Yes ☐ No ☐ Date Stopped Work Due to Accident _____

Employee Paid for Full Day on Day of Accident? Yes ☐ No ☐ Salary Continuation? Yes ☐ No ☐

Date Returned to Work (RTW) _____ RTW Full Duty? ☐ RTW Restricted Duty? ☐

How serious was the injury? (MUST Circle One)

A. Did not require treatment more than First Aid.
B. Required treatment more than First Aid, but did not result in lost time.
C. Resulted in lost time. *MUST HAVE DOCTOR'S EXCUSE FOR ANY LOST TIME*
D. Restricted activity.
E. Resulted in death.

EMPLOYEE STATEMENT _____

_____

I HAVE READ THIS REPORT AND IT IS CORRECT

EMPLOYEE SIGNATURE _____ DATE _____

SUPERVISOR'S NAME (PRINT) _____ DATE & TIME _____

SUPERVISOR'S SIGNATURE _____ DATE _____

NURSE'S SIGNATURE _____ DATE & TIME _____

NURSE'S PHONE _____ LOCATION _____

NURSE'S STATEMENT _____

_____

Incident must be reported immediately to Supervisor. Lost time and/or medical appointments must be reported to the Personnel Office within 10 days of incident. After 10 days Myra Pinker must be contacted.

Please contact Sharon Lauder at 926-1719 if you have any questions. March 2021

SOURCE OF INJURY CODES

CODE	DESCRIPTION
1	Material handling - Lifting, Carrying
2	Material handling - Pushing, Pulling
3	Material handling - N.O.C.*
4	Improper stacking or placing of material
5	Obstacles on surfaces - slips, trips
6	Falls to same level
7	Falls to other level
8	Operating equipment or machinery
9	Using hand tools
10	Using powered hand tools
11	Tools and Machinery N.O.C.*
12	Struck against object
13	Stepped on object
14	Burn - Chemical related
15	Burn - Other
16	Contact with Chemical
17	Eye Injury - N.O.C.*
18	Struck by object
19	Caught on or between objects
20	Not Listed - Other

NATURE OF INJURY CODES

CODE	DESCRIPTION
1	Sprain, Strain, Spasm, Tendinitis
2	Abrasion, Scratch, Contusion, Bruise
3	Pain
4	Cut, Puncture, Laceration
5	Eye Irritation, Foreign Body
6	Break, Fracture, Crush
7	Stress, Tension, Seizure, High Blood Pressure
8	Burn
9	Swelling, Cyst, Cellulitis
10	Soreness, Stiffness, Bursitis
11	Biological & Hazardous Material Exposure
12	Hernia
13	Poison Oak or Pollen Reaction
14	Sting or Bite
15	Pneumonia & Other Respiratory Problem
16	Heart Attack, Heart Condition
17	Hearing Loss
18	Concussion
19	Heat Exhaustion
20	Gun Wound
21	Cancer
22	Skin Irritation, Dermatitis
23	Multiple Injuries
24	Electric Shock
25	Not Listed - Other

BODY PART CODES

CODE	DESCRIPTION
1	Psyche
2	Head
3	Eye(s)
4	Ear(s)
5	Face, Nose, Mouth
6	Neck
7	Shoulder(s)
8	Chest
9	Heart
10	Other internal Organ
11	Upper Back
12	Lower Back
13	Hip(s)
14	Ribs or Abdomen
15	Posterior
16	Groin
17	Leg(s)
18	Knee(s)
19	Ankle(s)
20	Foot (Feet)Toe(s)
21	Arm(s)
22	Elbow(s)
23	Wrist(s)
24	Hand(s)
25	Finger(s)
26	Multiple - Upper Body
27	Multiple - Lower Body
28	Multiple - N.O.C.*
29	Not Listed - Other

*NOT OTHERWISE CLASSIFIED

WORKERS' COMPENSATION EMPLOYEE INFORMATION SHEET

You are receiving this information sheet because you have filed an accident report with the Frontier Central School District.

Please make sure that you have completely filled out the accident form, including **"How serious was the injury"** section. Below please find some information about the three categories that are used most often.

A. If you **did not require treatment more than First Aid,** your accident report will be filed just in case you have a future problem due to this accident.
B. **Required treatment more than First Aid, but did not result in lost time.** This means that you are going to a medical provider for an evaluation. You **must** have a medical from the facility that treats you that states you are" released with no restrictions". **There is no limited or light duty at Frontier.** If your medical provider puts you on limited or light duty – you cannot work. All medicals must be forwarded to the Personnel Office. Please call the Personnel Office at 926-1719 to notify us that you have been evaluated. You cannot return to work without a full release. A note stating you were treated is not a return to work note.
C. **Resulted in lost time** – If you are off due to an accident – you must have a doctor's excuse. The doctor's excuse must be submitted to the Personnel Office putting you off work and another excuse must be turned in to return to full duty.

If something changes after you fill out the form, please notify the Personnel office immediately. Any questions about Workers' Compensation should be addressed to the Personnel Office at 926-1719.

Our Workers' Comp carrier information is:

Triad Group
400 Jordan Road
Troy, NY 12180
1-800-337-7419

For all Lost Time and Medical Only claims, please contact
Michelle Lansing, Licensed Claims Adjuster – 1-800-337-7419 ext. 328