PROCEDURE TO FOLLOW WHEN A WORK RELATED INJURY OCCURS

When an employee accident, injury, or occupational illness occurs, report the incident **immediately** to your supervisor, department supervisor, or building principal. The original injury report should be forwarded to the Benefits Office with the proper signatures.

Whenever possible, employee injury reports should be filled out and completed the same day that the injury occurs. Please answer all questions that apply to you. Failure to do so may result in the loss of compensation benefits.

When an injury requires medical attention, the employee should seek treatment from their family physician, local walk-in clinic, or hospital unless a school nurse can treat an injury and determines that further treatment is not required.

A medical release from the attending physician should provide proof that the employee was treated. A diagnosis should be noted, any recommended restrictions, and the length of time needed before returning to normal duties.

NOTE: A C-4 form is to be completed by the physician and forwarded to the compensation carrier.

Payment for the treatment should NOT be made directly to the attending physician of hospital by the employee. This work related injury will not be covered by Blue Cross/ Shield. The charges will be covered by the Vestal Central School District's compensation carrier (Utica Mutual).

The employee may have to pay for prescriptions, apparatus, or crutches prescribed by the attending physician, but will be reimbursed fully by the compensation carrier, when a receipt is received for these items. **Do not use your prescription card for any of the above**. A record of all charges must be kept including mileage from your home to a physican or hospital for treatment.

A medical release from the physician will be required before an employee will be allowed to return to work. Notification from a supervisor or building principal when an employee is absent and/or returns, should be given to the Personnel Office. Please forward the original medical release from the physician to the Personnel Office.

An employee who is not able to return to work immediately will receive full pay for up to 22 calendar days per event, when the injury is determined to be work related and a physician's medical release is provided as proof of injury.

Any questions, contact the Benefits Office at 757-2228.

Vestal Central Schools
Vestal, New York
Employee Injury Report

Please print or type - include zip code in all addresses - employee's social security number must be entered below:

Date of Accident	Hour of Day	Carrier Case #	Work Telephone	Home Telephone	Employee's S.S. #

Injured Person (First, MI, Last)	Address	OSHA Case/File #

Name of Witness	Address

ACCIDENT

Address where accident occurred	County	Was accident on employer's premises? YES ☐ NO ☐

Time of accident AM PM	Dept. where regularly employed	Date stopped work because of this injury/illness	Was injured paid in full for day? YES ☐ NO ☐

INJURED PERSON

Sex	Age	Occupation (specific job title at which employed)

Supervisor's Name	Address

Part- or full-time worker?	Injured worker's work week (indicate days usually worked)

NATURE OF INJURY

Nature of Injury and part(s) of body affected	Did you provide medical care? YES ☐ NO ☐	If yes, when?

Name and address of doctor	Name and address of hospital

Has employee returned to work? YES ☐ NO ☐	If yes, date	Still under doctor care? YES ☐ NO ☐	If yes, date of next visit

CAUSE OF ACCIDENT

What was employee doing when injured? (Please be specific. Identify tools, equipment or material the employee was using.)

How did the accident or exposure occur? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how - use separate sheet if necessary.)

Object or substance that directly injured employee, e.g., the machine employee struck against or which struck him/her, the vapor or poison inhaled or swallowed, the chemical that irritated his/her skin. In cases of strains, the thing(s) he/she was lifting, pulling, etc.

Were safeguards provided? YES ☐ NO ☐	Were they in use? YES ☐ NO ☐	Was object or machine defective? YES ☐ NO ☐

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____

Reviewed by Benefit Department _____ Date _____

Failure to complete and return this form to benefit office could result in loss of compensation.