CAMDEN CENTRAL SCHOOL DISTRICT

WHEN AN EMPLOYEE SUSTAINS A JOB RELATED INJURY , THEY SHOULD COMPLETE THIS FORM. IT SHOULD THEN BE FORWARDED TO THE BUSINESS OFFICE AS SOON AS POSSIBLE . THANK YOU IN ADVANCE.

THE FOLLOWING INFORMATION IS REQUIRED TO COMPLETE AN "EMPLOYER'S REPORT OF INJURY" (FORM C–2). PLEASE ANSWER ALL QUESTIONS FULLY.

Date of Accident: ____/____/____ Name of Claimant: _____

Claimant's Address: _____ Social Security #: _____

_____ Sex: _____ Age: _____

School/Area where incident occurred: _____

Time: _____ AM / PM Date stopped work (if applicable): ____/____/____

Occupation: _____ Part time: ☐ Full time: ☐

Body part injured (indicate left or right where applicable): _____

_____

Medical care given at work: _____ Nurse Initials: _____

_____

Name and address of Physician: _____
(if one was seen)

Name of Hospital: _____
(if taken to a hospital)

Did you lose time at work due to this incident? YES ☐ NO ☐ If yes, Date Returned to work: ____/____/____

What were you doing when injured? (Be specific) _____

_____

_____

How did the incident occur? (Be specific) _____

_____

_____

Date you informed your Supervisor about the incident: ____/____/____

Supervisor's Signature: _____ Date: ____/____/____

I hereby certify that the above occupational injury report is correct to the best of my knowledge and belief.

Employee's Signature: _____ Date: ____/____/____