

# Madrid-Waddington Central School District

## Employee's/Supervisor's Accident Report for Workers' Compensation

(S) = Supervisor fills out

Employee Name: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Employee Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tel. #: ( ) \_\_\_\_\_

DOB: \_\_\_\_\_

Employee Soc. Sec. #: \_\_\_\_\_

Number of Dependents: \_\_\_\_\_

Married or Single: \_\_\_\_\_

Position: \_\_\_\_\_

Job Requirements: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_

Date of Hire: \_\_\_\_\_

Are you currently working for any other establishments? **Yes / No**

If yes, please state name, address and phone number: \_\_\_\_\_  
\_\_\_\_\_

What did you injure in the accident / nature of injury?: \_\_\_\_\_

Give detailed description of accident: \_\_\_\_\_  
\_\_\_\_\_

(S) Did Employee stop work? \_\_\_\_\_ (S) Time of Accident \_\_\_\_\_ A.M. / P.M.

Did you seek medical attention for the injury?: **Yes / No**

If yes, where and when?: \_\_\_\_\_  
\_\_\_\_\_

Were there any Witnesses to the accident? **Yes / No**

If yes, please give names and addresses: \_\_\_\_\_  
\_\_\_\_\_

(S) Are the Witnesses' statements different from those of the Employee?: **Yes / No**

(S) If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

Name and Address of Doctor: \_\_\_\_\_

Name and Address of Hospital: \_\_\_\_\_

(S) What was the Employee doing at the time of accident?: \_\_\_\_\_

(S) How did the accident occur?: \_\_\_\_\_

(S) Object or substance that directly injured Employee: \_\_\_\_\_

Over Please 

Do you have any pre-existing conditions or ailments, such as High Blood Pressure, Heart Conditions, Diabetes Etc.? **Yes / No**

If yes, please list them with the names of your treating physicians: \_\_\_\_\_

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Have you had any previous work related injuries? **Yes / No**

If yes, please state injury, approximate date of accident, and Employer at that time: \_\_\_\_\_

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Have you ever been in a car accident or have had any injuries at home?: **Yes / No**

If yes, please state injury and date and place of accident: \_\_\_\_\_

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Please list your hobbies and outside activities: \_\_\_\_\_

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**(S)** Is there a delay between the time of the accident and the time of this report? **Yes / No**

If yes, please explain why: \_\_\_\_\_

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**(S)** Are there any extenuating circumstances that you believe the Workers' Compensation Carrier should be Aware of? **Yes / No**

If yes, please explain: \_\_\_\_\_

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Employee's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**(S)** Supervisor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_