

**Cincinnatus Central School  
2809 Cincinnatus Road  
Cincinnatus, NY 13040  
607-863-3200**

**ACCIDENT REPORT**

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

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

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Department where regularly employed: \_\_\_\_\_

Occupation: \_\_\_\_\_

Nature of injury and body parts affected: \_\_\_\_\_

\_\_\_\_\_

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Did the school provide medical care? \_\_\_\_\_ If yes, When? \_\_\_\_\_

Name and address of doctor/hospital seen for injury/illness: \_\_\_\_\_

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Date work stopped because of injury or illness: \_\_\_\_\_

Date of return to work: \_\_\_\_\_

What were you doing when the injury/illness occurred? \_\_\_\_\_

\_\_\_\_\_

How did the injury/illness occur? \_\_\_\_\_

\_\_\_\_\_

Object or substance that directly injured employee: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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