City School District of Albany
Workers' Compensation Program
Employee Accident and Illness Report

SECTION 1: EMPLOYEE'S STATEMENT: Name (Last) (First) (MI)				Contact #:
Home Address	City	State	Zip	Date of Birth
Job Title:	Name of School:	Date of Accident:		Time of Accident:
Date Supervisor Was Notified:	Date Corvel Was Notified:	Exact Location of Accident (Example: Room Number, Stairwell, etc.)		
HOW AND WHY ACCIDENT OCCURRED; ALL BODY PARTS INJURED; NATURE OF INJURY				
Will you seek medical treatment?	Name of Medical Provider:			
Did you miss time from work?	Dates Missed from Work:			
Signature of Employee:		**Date Signed:**		
SECTION II: **EMPLOYER'S STATEMENT**		**Do you confirm this injury or illness? Yes___ No___**		
Signature of Supervisor/RN:		Date Signed:		
Name of Witness:		Witness Signature:		
Additional Details, if applicable:				
THIS REPORT IS BASED ON INFORMATION PROVIDED BY THE ABOVE EMPLOYEE: Signature of Principal: Date Signed:				

ALL INCIDENTS MUST BE REPORTED IMMEDIATELY TO YOUR SUPERVISOR & CORVEL'S EMPLOYEE INJURY CALL CENTER: 877-764-3574

Please send completed forms to the following within 48 hours of injury:
Office of Human Resources, 1 Academy Park, Albany, NY 12207
Office: 518-475-6090 opt 2 Fax: 518-475-6059