

**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:

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**