Employment Solutions

Employee's Report of Accident/Work Related Illness

This form must be completed and submitted to safety@employmentsolutions-ny.com or faxed to (888) 315.6608 WITHIN 24 HOURS of any on the job injury.

Part A: Injured Worker's Statement

Name: _____ Date of Birth: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip Code)

Social Security # _____ Phone #_____ Gender: ☐M ☐ F

Job Title: _____ Client Assigned to:_____

Date of Hire:_____ Employment Status: ☐Full-Time ☐Part-Time

Prior Accidents/Illnesses/Injuries, Known Medical Conditions, or Pre-Existing Disability? ☐Yes ☐No

Date of Accident: _____ Time:_____ AM/PM Time you began work:_____AM/PM

Where did the accident occur? (Please state building name & location in building)

_____

Describe the nature of your injury: (ex. Bruise/contusion, burn, cut, fracture, etc.)

_____

What part(s) of your body are affected by the injury? (ex. Hand, arm, leg, etc. – please be specific)

_____ ☐ Right ☐Left

Describe the accident below. Include what you were doing, how the accident occurred, and any equipment/objects/other people who contributed to the accident._____

_____

_____

_____

Describe any safety equipment worn when the accident occurred: (ex. Steel-toed shoes, safety glasses, etc.)

_____

Name & Phone # of any Witnesses: _____

_____

Employee Signature: Date:

Part B: Supervisor's Statement

Date/Time Injury was reported: _____ AM/PM

Describe what happened to cause the injury:_____

_____

_____

Initial Medical Treatment (check one):

- ☐ No medical treatment/treatment refused
- ☐ Minor/on-site treatment
- ☐ Clinic/hospital visit
- ☐ Emergency care
- ☐ Hospitalization > 24 hours
- ☐ Future medical treatment anticipated

Initial Medical Provider: (name, phone #, & address)

_____

_____

_____

_____

_____

Did injury result in time away from work? ☐ Yes ☐ No If Yes, last day worked: _____

Name & Phone # of any Witnesses: _____

_____

Describe what you would recommend to prevent a reoccurrence of this accident:

_____

_____

_____

IF THE INJURED WORKER RETURNS TO WORK OR BECOMES DISABLED AFTER THIS FORM HAS BEEN FILED IT IS IMPERATIVE THAT YOU NOTIFY RISK MANAGEMENT AT 607-732-7354 IMMEDIATELY.

Supervisor's Name_____ Phone # _____

Signature Date Completed

Part A is to be completed by the injured worker immediately after he/she has reported any on-the-job injury to his/her supervisor. All questions must be answered. The employee's signature is required.

Part A is to be verified by the Supervisor.

Part B is to be completed and signed by the supervisor. Discuss the occurrence in detail with the injured worker prior to completing this section. If you have any valid reason to believe the occurrence did not happen as described, use the word "Alleged" in your description of injury.

If injured worker is unable to complete Part A (ex. Emergency situation, injury reported via phone call, etc.), Part B must still be completed and returned to Risk Management immediately.

If injured worker leaves work early to seek medical treatment, he/she MUST provide a release to return to work from the treating physician before returning to work.

If you have any questions regarding the filing of this form, contact Risk Management.

Contact Info:

Risk Management
111 North Main Street
Mezzanine Level
Elmira, NY 14901

Phone: 607-732-7354
Fax: 607-732-7362
safety@employmentsolutions-ny.com