Employee Report of Work Related Injury

Please fill out entire form

Report Received by:
Date/Time Rcv'd:___/___/___ ____am/pm

1	Employee Name	Home Address (IF P.O. Box, also include physical location):	
2	Social Security #	Home Phone: ( )	Cell Phone: ( )
3	Volunteer: ☐ Yes ☐ No Contract Worker: ☐ Yes ☐ No	Hire Date: ____/____/____	Date of Birth: ____/____/____
4	Department:	Job Title:	# Yrs. in current position:
5	Job Title:	Work Location:	
6	Regular Days Off:	Start time on day of injury:	
7	# Yrs. in current position:	Direct Supervisor:	
8	Day of Injury: ☐Mon ☐Tues ☐Wed ☐Thurs ☐Fri ☐Sat ☐Sun Time of injury: ____am/pm Date of Injury: ____/____/____		
9	Date of Injury: ____/____/____		

10	Exact location when injured
11	Description of accident (be specific: i.e.: include object, machine, equipment, tools/material or substance involved, any special conditions, weather, etc.):
12	Part(s) of the body injured (be specific: right or left - finger, ankle, upper back, lower back, neck, etc.):
13	Type of injury (be specific: cut, scrape, burn, strain, etc.) If lifting, note item and approx. weight):
14	Was the activity within the course of employment? ☐ Yes ☐ No
	If not, explain:
15	Was safety equipment used? ☐Yes ☐No
16	Are you losing time from work: ☐Yes ☐No
17	How many hours of work did you miss on the date of injury?

Employee Report of Work Related Injury continued

18 Whom was the injury/accident first reported to (name/job title):

19 When was the injury/accident reported to the above individual (day/date/time):

☐Mon ☐Tues ☐Wed ☐Thurs ☐Fri ☐Sat ☐Sun Date: ____/____/____ Time: _____am/pm

20 Did the police respond? ☐Yes ☐ No
If yes, was a police report filed? ☐Yes ☐No Precinct:

21 Witness(es) to injury if any (Names/Titles/Phones): ☐ Check here if NONE

22 Medical treatment provided: ☐ Yes ☐ No If yes, date/time ____/____/____ _____am/pm
If no, please explain:

23 ☐ Check here if you refused medical assistance. Reason:

24 Did you go to a hospital or Medical Facility? ☐Yes ☐ No

If yes, transport: ☐ On own ☐ Ambulance (name) _____

25 If yes, provide the Date, Name, Address and Phone # of the Facility:

26 Did you go to your own doctor? ☐ Yes ☐ No
If yes, please provide Date(s), Name, Address & Phone Number of the Doctor:

27 Have you ever filed an Employee Report of Injury before? ☐ Yes ☐ No
If yes, provide the detail on prior claims (i.e.: dates, injury detail, etc.)

28 Is the current condition an aggravation of a previous injury/symptom? ☐ Yes ☐ No
If yes, when was the original injury?
When was the last treatment for the previous injury and by whom? (Date/Doctor Name)?:

The insurance Law of the State of New York provides that any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Claimant's Name (printed): _____ Date _____

(Claimant) Employee Signature: _____ Date _____

Prepared by (if other than claimant): _____
Preparer's printed name

_____ Date _____
Preparer's signature

Supervisor's Signature _____ Date _____
Supervisor's signature

Department Head Signature _____ Date _____
Department Head signature

Fax Completed Form Within 24 hours of injury to: Risk Management 845-808-1906