



## EMPLOYEE INCIDENT/ACCIDENT REPORT FORM

(Please Print)

Today's date:	Date of Incident/Accident:	Date Employee Benefits Manager Received:
<b>BASIC INFORMATION</b>		
Employee last name:	First: Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss    Phone Number: <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.    (    )    -
Time Work Day Began: <input type="checkbox"/> AM <input type="checkbox"/> PM	Date of Hire:    /    /	Birth date:    /    /    Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:	Social Security No.: XXX - XX - _____	Job Title:
P.O. Box:	City:	State:    ZIP Code:
Whom did you report the Incident/Accident to?	Date and time you reported it:	Did you receive an Injury Envelope? <input type="checkbox"/> Yes <input type="checkbox"/> No    If no, why?
<b>CLAIM INFORMATION</b>		
Date of Incident/Accident:    /    /	Time of Incident/Accident: <input type="checkbox"/> AM <input type="checkbox"/> PM	
Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Primary Position is: <input type="checkbox"/> 10-12 month <input type="checkbox"/> Other	Work Week Type: <input type="checkbox"/> Standard Work Week <input type="checkbox"/> Fixed Work Week <input type="checkbox"/> Varied Work Week
Work Days Scheduled: <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat		
<b>EMPLOYEE INJURY</b>		
Initial Treatment: <input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Emergency Evaluation	<input type="checkbox"/> Minor On-Site Treatment By Employer <input type="checkbox"/> Hospitalization Greater Than 24 Hours	<input type="checkbox"/> Minor Clinic/Hospital Treatment <input type="checkbox"/> Future Major Medical/Lost Time Anticipated
Did ICSD provide any medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date/Time:
Name of person providing treatment:		
Did you seek medical Treatment elsewhere? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date/Time:
Treatment/Facility Name:		Treatment/Facility Address:
<b>** IMPORTANT **</b>		
<b>All Medical Correspondence Must Be Submitted Straightaway to Your Supervisor or Human Resources Representative</b>		
Have you had a previous work-related injury to the same body part? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, When?		
Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc.):		
Part of Body (i.e. left arm, right foot, head, multiple, etc.):		
Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc.):		
Incident/Accident Description:		
<b>LOCATION AND WITNESSES</b>		
Location Where Incident Occurred:		
Is this your normal work Location? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Witnesses Name:		Witnesses Name:
Was there a delay between the time of the incident/accident and the time of this report? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, explain why:		

**SUPERVISOR COMPLETE**

Did the employee complete the shift?     Yes    No      Did you release the employee to leave early?     Yes    No

Did you remind employee to follow-up with you the next business day?    Yes    No

Was employee provided with an Injury Envelope?    Yes    No    If no, why?

What needs to change in order for this type of incident/accident not to reoccur?

- 1.
- 2.
- 3.

Was a Work Order necessary?    Yes    No

Date Work Order sent to Maintenance:

**Supervisor Signature:**

**Date:**

**FOLLOW-UP**

Actions taken on recommendations as outlined in by what needs to change?

1.	Date Completed:	By:	Dept./Title:
2.	Date Completed:	By:	Dept./Title:
3.	Date Completed:	By:	Dept./Title:

Check this box if you, the employee, independently and voluntarily request that your name NOT be entered on the OSHA Form SH-900 and you meet one or more of the qualifiers below (NYS DOL Log of Work Related Injuries and Illnesses). If checked, treat as a privacy concern case.

The employer must consider the following injuries/illnesses to be privacy concern cases:

- 1. An injury/illness to an intimate body part of the reproductive system;
- 2. An injury/illness resulting from a sexual assault;
- 3. Mental illnesses
- 4. HIV infection, hepatitis, or tuberculosis;
- 5. Needle stick injuries and cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material;
- 6. Other illnesses, if the employee independently and voluntarily request that his or her name not be entered on the log. Effective January 1, 2004; Musculoskeletal disorders (MSD's) are not considered privacy concern cases.

This is a complete list of all injuries/illnesses considered privacy concern cases. No other types of injuries/illnesses may be classified as privacy concern cases.

*By signing below, I verify that the information provided in the report is true, complete and accurate to the best of my knowledge. I understand that any willful omission of &/or falsification is fraudulent and may be punishable to the fullest extent under Section 114a of the NYS Workers Compensation Law. Furthermore, I also understand that completion of this document does not imply or guarantee acceptance of this claim by my employer or insurance carrier.*

**Employee Signature:** \_\_\_\_\_ **Date:**    /    /

**Supervisor Signature:** \_\_\_\_\_ **Date:**    /    /

Office Use Only: \_\_\_\_\_ Case number from the SH-900 Log: \_\_\_\_\_  
(Transfer the case number from the Sh-900 log after you record the case.)

**\*\* Due to strict Workers Compensation Guidelines, this form must be forwarded A.S.A.P. to: Marta Costa-Potter in the Business Office \*\***