SUNY Brockport
Employee On-the-Job Accident and Injury Report

PART 1: To be completed by the employee * (also see Part 3)

*Note: If the employee cannot complete the initial form, due to injury, then the supervisor or representative needs to complete and submit to HR. The employee will also need to complete their own form, when able.

Employee's Name:	Social Security Number: xxx-xx-
Address:	Home Telephone:
	Work Telephone:
Title:	Bargaining Unit:
Shift: (list work hours)	Pass Days:
☐ Full-time ☐ Part-time Other (student / volunteer, etc.) ☐	Date of Birth:
Line #:	Gender: ☐ Male ☐ Female
Date of Employment:	Time of Accident: a.m. or p.m.
Date of Accident:	Did employee remain on duty day of injury? Yes ☐ No ☐
Name of Supervisor:	NYS ARS Incident Number (see part 3) :

Was medical treatment provided? Yes ☐ No ☐ Not at this time ☐ Unknown ☐ If yes, give name, address and phone # of physician and/or hospital, type of the first medical treatment and date of the first medical treatment. If you have a doctor or hospital visit, you will need to sign in at Human Resources, and submit a medical note (initial visit and any others) indicating that you were seen for your work injury and your status (return to work & date, or excused from work until date).

Is the employee still being treated for the injury/illness? Yes ☐ No ☐

Was treatment provided in an emergency room? Yes ☐ No ☐
Was employee hospitalized overnight? Yes ☐ No ☐

Was the injury a result of the use of a motor vehicle ? Yes ☐ No ☐ If yes, License Plate Number: _____

Was the injury a result of an assault or restraint ? Yes ☐ No ☐ If yes, check if it was ☐ assault or ☐ restraint.

On the day of the injury, the employee started work/shift at: _____ A.M. _____ P.M.

At the time of the injury, was the employee working overtime ? Yes ☐ No ☐

What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Attach an additional page if necessary.

Employee's Name: _____ Date of Injury: _____

What happened? Tell how the injury and where the injury occurred. Attach additional page, if necessary.
List the exact physical location of where the injury/accident took place:
Inside or Outside, Parking Lot, Field, Building, N, E, S or West side, Stairwell, Bldg. Floor #, Room, etc.

What was the injury or illness? Tell what part of the body that was affected and how it was affected; be more specific than "hurt", "pain", or "sore." Include "right" or "left" to indicate exact location.

What object(s) or substance(s) directly harmed the employee? Please be specific.
Examples: "concrete floor"; "ice on sidewalk", "radial arm saw/tool", "chlorine/cleaning product", "heavy garbage bag", etc.

_____ _____
Signature of Employee **Date**

Form completed by: Employee ☐
Supervisor ☐ **Name / Title**_____ **Other** ☐ **Name / Title**_____

EMPLOYEE PERMISSION: (Choose **ONE** option by signing)

I, _____, independently and voluntarily request that my name **NOT** be entered on the "*Log of Work-Related Injuries and Illnesses or injury*," in case of work-related illnesses or injury, which may be released to employees, former employees, their personal representatives and authorized employee representatives without further notice to me.

I, _____, understand that my name **WILL** be entered on the "*Log of Work-Related Injuries and Illnesses or injury*," in case of work-related illness or injury, which may be released to employees, former employees, their personal representatives and authorized employee representatives without further notice to me.

Employee's Name: _____ Date of Injury: _____

PART 2: To be completed by supervisor * and witness
If form not completed by direct line supervisor,
please indicate both your name/title, and direct line supervisor of employee.

Has the employee given you notice of injury/illness? If yes, Verbal ☐ In Writing ☐ Both ☐

Date/Time notice given _____ Name/title of person notice was given to_____

Please give the exact work schedule (specify work days and shift/hours of work):

_____

Is the physical location where the injury occurred, a normal work location for the employee? Yes ☐ No ☐
If no, reason employee was there_____

Did Supervisor or supervisor representative see the injury happen? Yes ☐ No ☐ Unknown ☐

To your knowledge, did the employee have another work related injury to the same body part or similar illness while working for you? Yes ☐ No ☐ explain if yes_____

What type of activities does the employee normally perform at work?
Examples: cleaning, snow shoveling, grounds work, manual labor, moving items, office clerical, teaching, etc.
_____
_____
_____

Supervisor (and/or Representative) Statement: (Attach additional page, if necessary)
_____
_____
_____
_____
_____
_____
_____

Supervisor Name and Title (Please Print) _____

Supervisor campus location and phone #: _____

Signature of Supervisor_____ Date _____

Employee's Name: _____ Date of Injury: _____

Name(s), Title(s) if employee(s), Address(es), and Telephone Number(s) of Eyewitness(es):

_____ _____
_____ _____
_____ _____
_____ _____

Statement of Eyewitness(es) (attach additional page for statements and signatures, if necessary):

_____
_____
_____
_____
_____
_____
_____

Signature of Eyewitness _____ Date _____

PART 3:

Information on this report must be forwarded to the Office of Human Resources immediately following an on-the-job accident or injury. **This document is required under NYS PESH Rule Part 801.** Employees also must report the accident to the NYS Accident Reporting System (ARS), 1-888-800-0029. If medical care provided at later date, employee will need to call ARS again to report medical.

All contact from the State Insurance Fund will be to the employee's home. Therefore, it is very important that the complete home address and telephone number, including area code, be provided.

If the injury requires treatment by a physician or hospital, the employee should advise that the accident is work related and that the College's insurance carrier is the NY State Insurance Fund, 100 Chestnut Street, Suite 1000, Rochester, NY 14604, 585-258-2000.

The injured employee's supervisor is responsible for notifying the Office of Human Resources of the exact dates the employee is absent from work due to the accident or injury. Any subsequent lost time also must be immediately reported to the Office of Human Resources.