For HR use

Incident #: ________________
NYBEAS: ________________
C3 Sent: ________________
Safety Officer: ________________

Employee Accident & Investigation Report

A. Call the Accident Reporting System at 1-888-800-0029 Monday - Friday 8am to 5pm
B. Follow the directions on the second page of this form, please answer every question
C. Return this completed form to your supervisor for their review and signature
D. Please send to Human Resources: fax 746-4158 OR e-mail to humanresources@delhi.edu OR send inner office mail to HR: Bush Hall

Employee Name: ______________________________ Bargaining Unit: ______________________

Employee Address: ____

Date of Birth: ______________________________ Female Male

Social Security Number: ______________________ Cell/Home #: ______________________

Job Title: ______________________________ Department: ______________________

Your date of hire: ______________________ Full Time Part Time

Shift: ______________________________ Pass Days: ______________________

Primary Work Location: ______________________ Work Phone: ______________________

Work Address: ____

Accident Date: ______________________ Time of Accident: ______________________

Location of Accident: ____

Type of Injury: ______________________ Body Part(s) affected: ______________________

After the accident, did you continue working? Yes No

Have you returned to work? Yes No

If yes, what date did you return? ______________________

Did you require medical attention? Yes No If yes, what date? ______________________

Name of Doctor: ____

Name & Address of Hospital: ____

What were you doing when you where injured? (Please be specific: identify tools, equipment or material that you were using)

____

How did the accident or exposure occur? (Describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened.) ____

____

Object or substance that directly injured employee? (e.g. the machine employee struck against or which struck him/her; the vapor or poison inhaled or swallowed; chemical that irritated his/her skin. In cases of strains, the thing(s) he/she was lifting, pulling, etc.)

____

____

Names of eyewitnesses: ______________________________ Witness Statement Attached: Yes No

Employee Signature: ______________________________ Date: ______________________

Supervisor's Work Address: ______________________ Supervisor's Work Phone: ______________________

Supervisor's Statement: ____

____

Supervisor's Signature: ______________________________ Date: ______________________

Directions for Completing this Form

Item 01 Employee's name, as it appears on payroll stub and his/her Negotiating Unit (e.g. OSU).

Item 02 Employee's current mailing address.

Item 03 Employee's Social Security number, as it appears on the employee's payroll stub. Employee's current home telephone number.

Item 04 Employee's date of birth. Indicate employee's sex by checking male or female.

Item 05 Employee's job title and normal work location.

Item 06 Employee's normal shift, i.e., days, evenings or nights (specify hours); the days the employee is normally off duty. Indicate whether the employee works full or part-time.

Item 07 Employee's campus address and phone number.

Item 08 The date the employee was hired.

Item 09 The date and time the employee was injured.

Item 10 The building and floor, unit, or other information to indicate where the accident occurred.

Item 11 Indicate exactly what the injury is and what body part(s) have been affected (e.g., sprain to right ankle, cut to the left forearm, cuts to knees of both legs).

Item 12 This item must be checked after determining whether or not the employee was able to remain at the normal work station. If known, please indicate whether or not the injured employee has returned to work and, if the employee has returned to work, indicate their date of return. **Item 13** Check to determine whether employee required medical attention either immediately after the accident or at some subsequent date. If unknown, check NO. If yes, indicate the name and address of the doctor and/ or hospital.

Item 14 Identify the tools, equipment or material that the employee was using and what he/she was actually doing at the time of the injury/illness. Please be specific.

Item 15 Fully describe the events that resulted in the injury or exposure. Specifically explain what happened and how it happened. Particular objects, unsafe conditions, or other factors contributing to the illness or injury should be mentioned.

Item 16 Indicate the machine or tool that caused the injury; the vapor or substance inhaled or swallowed; the chemical that irritated the employee's skin. In cases of strains, the object(s) the employee was lifting, pulling, etc.

Item 17 Employee's signature and date employee completed the form. If the employee is unable or unavailable to sign, please leave blank.

Item 18 Names of eyewitnesses who were present and saw the accident occur, with their description of what happened.

Item 19 The assigned supervisor should describe any condition that may exist or any other relevant information concerning the accident.

Item 20 Supervisor's signature and date the supervisor completes the report.

Item 21 Supervisor's campus work location and telephone number.

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. **Any person who knowingly with intent to defraud makes a materially false statement or conceals a material fact to obtain a benefit, shall be guilty of crime. Reports suspected of Workers Compensation fraud will be sent to the Workers Compensation Fraud Inspector General of Albany, NY**