SUNY ONEONTA
EMPLOYEE REPORT OF WORK-RELATED INJURY/ILLNESS

INSTRUCTIONS

EMPLOYEE:

1. WITHIN 24 HOURS OF INCIDENT, OR AS SOON AS POSSIBLE THEREAFTER, CALL THE NYS ACCIDENT REPORTING SYSTEM (ARS) AT 1-888-800-0029.
2. COMPLETE BOTH SIDES OF THIS PAGE, PROVIDING AS MUCH DETAIL AS POSSIBLE. BE SPECIFIC. FOR ALL TIMES, INCLUDE IF AM OR PM. DETACH THIS PAGE AND SUBMIT IT TO YOUR SUPERVISOR.
3. RETAIN AND REVIEW ATTACHED PACKET. SUBMIT THE FORM C-3 TO THE WORKERS COMPENSATION BOARD AS SOON AS POSSIBLE TO ESTABLISH YOUR CASE AND AVOID POTENTIAL LOSS OF BENEFITS. FAX IT TO 877-533-0337.

SUPERVISOR:

1. UPON RECEIPT, OR AS SOON AS POSSIBLE THEREAFTER, COMPLETE YOUR SECTION OF THIS FORM AND SUBMIT IT TO HUMAN RESOURCES, 208 NETZER.
2. IF EMPLOYEE IS UNABLE TO COMPLETE THIS FORM, COMPLETE AS MUCH AS POSSIBLE OF THE EMPLOYEE SECTION, COMPLETE YOUR SECTION, AND SUBMIT FORM TO HUMAN RESOURCES.

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Employee information

Name: _____ Dept regularly assigned: _____

Personal daytime phone: _____

Campus phone: _____ Dept assigned at time of incident: _____

Incident date/time

Time began work on day of incident: _____

Date of incident: _____ Time of incident: _____

Date this form/packet received: _____ Time this form/packet received: _____

Date ARS called: _____ Time ARS called: _____

Incident number assigned: _____ Working overtime? YES ◯ NO ◯

Detail of incident – BE VERY SPECIFIC

Location *(building, floor, room, field, walkway, etc.):* _____

_____

What were you doing immediately prior to incident? *(moving furniture/equipment, climbing ladder, carrying books, walking, etc.):* _____

_____

What happened? *(slipped on ice, lost my grip, felt a twinge, etc.):* _____

_____

Describe injury/illness – include body part and left, right, upper, middle, lower *(strained lower back, twisted left ankle, developed skin rash):* _____

_____

What object was directly involved *(ladder, glass door, spilled chemical):* _____

_____

(continued on other side)

Notification/Witness

Name(s) of person(s) you notified: _____

Date of notice: _____ Time of notice: _____

Notice provided: VERBALLY ◯ IN WRITING ◯ BOTH ◯

Were there any witnesses? YES ◯ NO ◯

Name of witness(es): _____

Supervisor's name: _____ Did supervisor witness incident? YES ◯ NO ◯

Date supervisor notified: _____ Time supervisor notified: _____

Medical information

Did you receive medical attention? YES ◯ NO ◯

Date of first treatment: _____ Time of first treatment: _____

Type of treatment: ER ◯ Urgent care ◯ Physician's office ◯

Name of facility: _____ Provider's name: _____

Address of facility: _____

Admitted into hospital: YES ◯ NO ◯ Date admitted: _____

Name/address of hospital: _____

Lost time

Did you stop working? YES ◯ NO ◯

Date stopped: _____ Time stopped: _____

Date returned: _____ Time returned: _____

Confirmation

_____ _____

Employee's signature Date

Supervisor's statement

Date notified of incident: _____ Time notified: _____

Did you witness incident? YES ◯ NO ◯

Comments, if any: _____

_____

_____ _____

Supervisor's signature Date

Rev. 03/2015