Form WC-1

State University of New York College at Cortland
Employee Injury, Illness, Medical Emergency Report

Please Print:

Accident Reporting System (ARS) Incident #_________________ (you must call 1-888-800-0029)

Date of Accident ________________________ **Time of Accident** ______________________________

1. Name____ Date of Hire ________________________________

2. Home Address____

   Tel: (home)__________________ (work)___________________ Date of Birth _______________________________

   Gender { } Male { } Female Normal Work Hours__________________ Pass Days ____________________

3. Job Title______________________________________ Dept.____

4. Campus Work Location__________________________

5. Place of Accident (be specific) ____

   Was injured individual in an authorized work area { }yes { } no

6. Nature and Part(s) of Body Affected (be specific- include left or right side if appropriate)_____________________________

   ____

7. Employee Remained on Duty { }Yes { }No Date of first full day of absence________ Date returned to work__________

8. Employee required medical attention { }Yes { }No If yes, when?_______________________

   Type of medical treatment { }first aid only { }emergency room { }doctor visit

   Name & address of Doctor____

   Name & address of hospital____

   Was employee hospitalized overnight? { }Yes { }No

9. What was employee doing when injured (be specific, identify tools, equipment or material the employee was using)

   ____

   ____

   ____

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

    ____

    ____

11. Object or substance that directly injured employee (e.g. “concrete floor”, “radial arm saw”, “chlorine”, in the case of strains – identify object that caused strain, lifting, pulling etc.)

    ____

    ____

12. Were there any witnesses? { }Yes { }No If yes, list names and contact information:_______________________________

    ____

_______________________________________ _______________________________

Employee Signature Date

_______________________________________ _______________________________

Supervisor Signature Date

RETURN COMPLETED FORM TO HUMAN RESOURCES, MILLER ADMINISTRATION BLDG., ROOM 301