

## Work-Related Employee Injury / Illness Incident Report For State Employees

EH&S USE ONLY	
<ul><li>☐ Recordable</li><li>☐ Non-Recordable</li></ul>	

Attention: This form contains information relating to empl	loyee health and <u>MUST</u> be used in a	manner that protects the confidentia	lity of employees.	
Accident Reporting System (ARS) Incide	nt #:	(you must call 1-888-800-0029)		
Date of Accident:	<u> </u>	Time of Accident:		
SECTION 1 – EMPLOYEE INFORMATION: TO BE CO	DMPLETED BY EMPLOYEE AND	/ OR SUPERVISOR		
Last Name: First Na	me:	Home Phone:		
Home Address:	City:	State:	Zip:	
Date of Birth: Gender:	Male 🗆 Female			
Job Title:	Employee ID #:	Date of Hire:		
Employee's Department:	Normal work hou	urs: Pass days:	mm/dd/yyyy	
SECTION 2 – INJURY / ILLNESS INFORMATION: TO	D BE COMPLETED BY EMPLOY	EE AND / OR SUPERVISOR		
Location of injury or illness (bldg. / area):				
Specific location of injury or illness (room, stairwell	l, etc.):			
Did the employee remain on duty? $\square$ Yes $\square$ No				
Did the employee seek medical attention? $\Box$	Yes 🗆 No If Yes, when?			
Type of medical treatment: $\square$ First Aid Only $\square$ E	mergency Room 🗆 Doctor's V	ïsit		
Date employee stopped work because of this injur	y or illness:	_ Date employee returned to do		
What was the employee doing JUST BEFORE the using. Be specific (Examples "I was standing on a ladder and real			mm/dd/yyyy als the employee was	
What happened? Tell us how the injury occurred. (Examp	ole: "The ladder slipped on wet floor ar	ıd I fell to the floor 6 feet below landing	g on my right side").	
What was the injury or illness? Tell us the part of the than "hurt", "pain", or "sore" (Example: "Contusion to right should be a solution or the contust of		e of the injury / illness (how it was affec	ted); be more specific	
	nployee independently and voluntarily is box is checked, treat as a privacy co	requests that his or her name <b>NOT</b> be encern case.	entered on the	

Employee's name:		Date of Injury or Illness:			
SECTION 3 – MEDICAL IN	IFORMATION: TO BE CO	OMPLETED BY EMPLOYEE, SUPERV	ISOR AND / OR ME	DICAL PROVIDER	
Type / nature of injury:					
$\square$ Amputation	$\square$ Burn (chemical)	$\square$ Cut/laceration - sutures	$\square$ Chest Pain	$\square$ Contaminated sharp	
$\square$ Contusion/bruise	$\square$ Burn (heat)	$\Box$ Cut/laceration – no sutures	$\square$ Dislocation	☐ Puncture	
$\square$ Exposure (chemical)	☐ Fracture	☐ Hernia/rupture	$\square$ Poisoning	$\square$ Loss of consciousness	
$\square$ Exposure (biological)	☐ Sprain/strain	□Other			
Type of medical treat given:	ment				
☐ First aid only (i.e., no	n-prescription streng	th medications, band-aids, eye ¡	oatches, immobiliz	ation devices, etc.).	
☐ X-ray Was prescrip	tion (Rx) prescribed or c	dispensed? ☐ Yes ☐ No If yo	es, what medication		
Date of visit:	Time of visit:	□ AM □ PM Body	part affected:		
Medical treatment prov			_		
Was the employee hospit	alized? 🗌 Yes 🗆 N	o If the employee expired, provi	de date: T	ime:	
Medical facility / doctor r	name:			Phone:	
Medical facility / doctor a	address:	City:	Sta	te: Zip:	
Are you (the employee) a	ble to return to work?	☐ Yes ☐ No	If no, for how	many days:	
Name (Print):		Signature:		Date:	
CECTION A NAME NECE	CTATEL IENT / CLIDES	)	ESTICATION LSTAT	mm/dd/yyyy	
	STATEMENT / SUPER	rvisor injury or illness inv	ESTIGATION STA	IEMENI	
Statement of witness:					
Name (Print):		Signature:		Date:	
	ness investigation state	ement: (Provide confirmation of the	ne incident to the ex	mm/dd/yyyy	
		sor see the injury happen? $\square$ Yes		reent possione, eduse(s) and	
Name (Print):		Signature:		Date:	

NOTE: This report 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 employee who files a false report will be subject to the appropriate administrative action including disciplinary action pursuant to the applicable collective bargaining unit.

## **EMPLOYEE INSTRUCTIONS:**

- 1. Report your injury or illness to your direct supervisor or their designee immediately.
- 2. Get medical attention if needed. Report to the nearest clinic or hospital emergency department during off hours or in a life-threatening emergency, and inform them that your injury is work-related.
- 3. The employee's supervisor and/or your private medical provider are responsible for completing their section(s) of this report. If you have not received medical attention at this time, this must be noted on the report. NOTE: If medical attention is sought at a later date, documentation must be provided from your private medical provider to Human Resource. Human Resource will notify Environmental Health and Safety (EH&S), for OSHA/PESH recordkeeping purposes.
- 4. The employee must call the NYS Accident Reporting System (ARS) at 888-800-0029 to report the incident and receive an ARS incident number. The ARS incident number must be added to the report.
- 5. All occupational injuries or illnesses that occur to employees while on duty must be promptly reported by the employee to fulfill legal reporting requirements under the NYS Workers' Compensation Laws, the Occupational Safety and Health Administration (OSHA), and the Public Employee Safety and Health Bureau (PESH).
- 6. **Complete this report within 24 hours after a work-related injury or illness.** Return the completed report to your supervisor or designee for proper distribution.
- 7. Supervisors are required to perform an investigation of the injury or illness to determine the root cause(s) and their corrective action(s) to be taken to prevent the incident from being repeated. This information must be provided in the Supervisors Statement section of the report.
- 8. The Employee Injury/Illness Incident Report must be completed in its entirety and signed legibly.
- 9. If the employee was exposed to a hazardous material or a bloodborne pathogen (BBP) the employee must be evaluated by the local clinic or hospital emergency department; however, the employee is not required to accept treatment. If the injury involves a BBP they must be evaluated within 2 hours of the injury.
- 10. Notify your direct supervisor or their designee and Human Resources if your private medical provider extends the off-duty time beyond the time authorized by the local clinic or hospital emergency department.
- 11. If subsequent medical attention is received, documentation must be provided from your private medical provider to Human Resources. The note from your private medical provider should contain a diagnosis code, prognosis, estimated date of return, and detail any restrictions and / or limitations and the duration they are expected to be in place.

## Important:

Promptly completing all of the above steps for reporting your work-related injury/illness will ensure payment of all your compensable medical bills and lost work time. In order for the New York State Insurance Fund to evaluate your case for payment of your Workers' Compensation wage replacement benefits and medical bills they need to have a copy of your injury/illness report from your employer, ARS notification, and a medical report from a physician indicating your disability is due to your job-related injury.

## Distribution:

Human Resources, Miller Administration Building Room 301 Environmental Health & Safety, Service Group Room 108