WORK-RELATED INJURY / ILLNESS INCIDENT REPORT

(This form must be completed and forwarded to your supervisor within 24 hours)

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.

EMPLOYEE INFORMATION:

Name: _____

Mailing Address: *(Street)* _____

(City) _____ *(State)* _____ *(Zip)* _____

Telephone Number: _____

Social Security #: _____ **Male**_____ **Female**_____

Date of Birth:_____/_____/_____ **Hire Date:**_____/_____/_____

Position Title:_____ **Full Time** _____ **Part Time** _____

Name of Supervisor:_____ **Division:**_____

PHYSICIAN / HEALTH CARE PROFESSIONAL INFORMATION:

Was employee treated by a medical professional? Yes _____ **No** _____

Was employee hospitalized overnight? Yes _____ **No** _____

Name of medical professional:_____

Facility:_____

Mailing Address: *(Street)* _____

(City) _____ *(State)* _____ *(Zip)* _____

INFORMATION ABOUT THE CASE: **(Case # provided by HR/Personnel: _____)**

Date of Injury or illness: _____/_____/_____ **Date reported to Supervisor:** _____/_____/_____

Time employee began work: _____ **Time of event:**_____

Date stopped work because of this injury/illness: _____/_____/_____

Name and address of school or other site where injury/illness occurred:

(School or Site) _____
(Street) _____
(City) _____ *(State)* _____ *(Zip)* _____

Where the event occurred *(e.g., hallway, classroom, etc.)* _____

1. **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.)*

_____

_____

_____

2. **What happened?** *(Tell us how the injury occurred.)*

_____

_____

_____

3. **What was the injury/illness?** *(Tell us the part of the body (e.g. right hand) that was affected and how it was affected)*

_____

4. **What object or substance directly harmed the employee?**

_____

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*," 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. I, _____, understand that my name WILL be entered on the "*Log of Work Related Injuries and Illnesses*" 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.

I, the undersigned, authorize any physician or nurse who has treated me or any hospital at which I have been confined, to furnish to any authorized representative, any and all information which may be requested regarding my physical condition and treatment rendered thereof and if necessary to allow them or any physician appointed by them to examine any x-rays taken of me or records regarding my physical condition or treatment. A photocopy of this authorization shall be as valid as the original.

Injured Employee Signature: _____ **Date:** _____

Supervisor's Signature: _____ **Date:** _____

Forward this Report to the Human Resources Office WITHIN 24 HOURS

Jennifer Bouldin – Data Control Clerk - Human Resources Department
Cattaraugus-Allegany BOCES – 1825 Windfall Road – Olean, NY 14760
716- 376-8242 (direct line) - 716-376-8430 (fax)