Instructions for completing a Workers Compensation Accident/Injury/Occupational Illness Report:

1) Employee Information section: Complete all fields in full. This information will be used to establish your claim with our carrier if there is lost time or medical treatment beyond first aid. Please print neatly or type in all the information specified. This is important because a copy of every report must be submitted to our carrier. Please use full legal name, full social security number and full addresses.

2) Accident/Injury/Onset section: Be sure to give the name of the building where the injury occurred as well as the full street address. If it occurred in a specific room or section of the building please specify that as well.

3) When treatment other than first aid is rendered it is critical that Personnel receive all information regarding the treatment. The type of treatment rendered directly affects both the forms we are required to submit to the Workers Compensation Board and the injuries that are reported to the Public Employees Safety and Health Bureau. **Personnel must be notified immediately if an employee seeks treatment, other than the school nurse, for the injury. When any treatment is sought contact Molly Lawson at 315-433-2641 immediately!**

4) If treatment is rendered after the incident report has been submitted send any treatment information directly to the Personnel Department at Main Campus. Be sure to indicate that this is for a Workers Comp injury and the date of injury. **Again, notify Personnel immediately, at 315-433-2641 when treatment is rendered, even after the injury report has been submitted!**

5) When describing the injury or illness be specific. Is it a sprain, strain, contusion, abrasion, fracture, human bite, etc. Be sure to specifically designate all body parts affected, for example left leg, right foot, left side of neck, etc

6) When describing how the injury occurred be specific. Attach an additional sheet if you need more space to explain.

7) Your supervisor must sign the Accident/Injury/Occupational illness Report. If the report is completed with someone other than your supervisor be sure that person mails, scans and emails, or faxes the report directly to your supervisor for signature. If there is lost time or immediate treatment required we must submit the report to our carrier within 10 days of the incident, so time is critical. A duplicate copy can be emailed or faxed to the Personnel Department to get the process rolling, while the supervisor's signature is being obtained. Your claim cannot be submitted to our carrier until a copy of the report is received.

8) If you lose time from the injury you must supply a doctor's note taking you out of work. The note must specify the reason for the absence, the approximate duration of the absence or the date of your next follow up.

9) If you have any additional questions with regard to your claim, you can contact **Molly Lawson** in Personnel at **315-433-2641.**

***I have read and understand the instructions above. I understand that it is my responsibility to provide accurate and timely information regarding my claim including any documents related to treatment of this injury/illness, even if treatment is sought after submission of this report.

_____ _____

Employee Signature (REQUIRED ON BOTH PAGES) Date

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OCMBOCES
Committed to Your Success

For Office Use Only:
Hire Date_____
Daily Rate_____

Workers' Compensation Accident/Injury/Occupational Illness Report

Employee Information – All items must be completed

*Employee Full Name (First, MI, Last) _____

*Mailing Address (No. and Street or PO Box) _____

*Full Social Security Number _____ *Date of Birth _____

*City, State, Zip _____ *Phone # _____

*Job Title _____

*Division/Program/Supervisor _____

*Days of Week Normally Worked (Monday, Tuesday, Etc.) _____

*Gender ☐ Male ☐ Female

Accident/Injury/Onset

Date of Injury/Onset _____ Time of Injury/Onset _____ (AM or PM)

Did you stop work due to the injury? ☐ No ☐ Yes _____
(Do not include day of injury) (If yes, first full day of work lost)

Has Employee Returned to Work? ☐ No ☐ Yes _____
(If yes, date of return)

Witness(es) _____ _____ _____

Contact Number of Witness(es) _____ _____ _____

Building Name and Address where injury occurred. Include specific room name if applicable
_____
_____
_____

Description of Injury and Details of Treatment

Describe your injury: (Eg: sprain, strain, contusions, bite, lacerations, etc. Be sure to include specific body parts affected and if it was the left, right, upper, lower, etc.))

Is this a recurrence of a previous injury or illness? ☐ No ☐ Yes (If yes, give date(s)/details)

Was employee seen by school/building nurse? ☐ No ☐ Yes

Any EMT or Ambulance Service used? ☐ No ☐ Yes

Did employee receive treatment other than school nurse? ☐ No ☐ Yes (If yes, attach supporting documents from ER/Urgent Care/Doctor visit. Include details of any treatment rendered including prescription drugs, stitches, x-rays, etc. Please notify **Molly Lawson** in Personnel immediately at **315-433-2641** if treatment other than nurse is required).

Where was treatment rendered? (Include name of facility and address)

☐ Doctor Office _____ Date _____

☐ Urgent Care _____ Date _____

☐ Emergency Room _____ Date _____

Cause of Accident, Injury, Occ. Illness

How did the injury/occupational illness occur? (Describe in detail what happened and how. Use an additional sheet if necessary)

What was the employee doing at the time of the accident? (Be specific, identify tools, equipment, or materials the employee was using. Specify object or substance that directly injured employee, if applicable)

_____ _____
Signature of Injured Person (EMPLOYEE SIGNATURE REQUIRED ON BOTH PAGES) Date

_____ _____
Signature of Employee's Supervisor Date