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:** Time of Injury/Onset can be rounded to the nearest 5 minutes. Be sure to give the name of the building where the injury occurred as well as the full street address. If the incident occurred in a specific room or section of the building, please specify that as well.

3) 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 (ex. left leg, right foot, left side of neck, upper back, lower arm, left index finger, etc).

4) When treatment other than first aid (school/building nurse) 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 outside treatment (Urgent Care, Er, Doctor) for the injury. When any treatment is sought, contact the Workers Compensation Liaison (Molly Lawson) at 315-433-2641 immediately!

5) If treatment is rendered after the injury report has been submitted, send any treatment information directly to the Personnel Department at Main Campus (Dr's Notes, Discharge paperwork, etc.). Be sure to indicate that this is for a Workers Comp injury and the date of injury.
   Again, notify the Workers Comp Liaison immediately at 315-433-2641 when treatment is rendered (Urgent Care, ER, Doctor), even after the injury report has been submitted!

6) **Cause of Accident/Injury section:** 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 Workers Comp Liaison in 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 by the Workers Comp Liaison.

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 the **Workers Compensation Liaison** (Molly Lawson) in the Personnel Office 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

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 _____

*Job Title _____

*Division & Supervisor/Program _____

*Phone Number _____

*Gender ☐ Female ☐ Male

*Work Day Start Time (ex. 8:00am, 8:15am, Etc.) _____

*Days of Week Normally Worked (Mon, Tues, Wed, Etc.) _____

*Personal Email _____

Accident/Injury/Onset

Date of Injury/Onset _____ Time of Injury/Onset _____ ☐ AM ☐ PM

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

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

Witness(es) (First & Last) _____ _____ _____

Witness(es) Phone #(s) _____ _____ _____

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

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)

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

CERTIFICATION: I CERTIFY THAT THIS ACCIDENT/INJURY REPORT IS COMPLETE AND ACCURATE. FALSE REPRESENTATIONS COULD RESULT IN CIVIL AND CRIMINAL PENALTIES

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

_____
Date

_____
Signature of Employee's Supervisor

_____
Date