DIRECTIONS: **Employee**: Complete Employee Section and give to your supervisor within 24 hours of incident.

Supervisor: Complete Supervisor Section and then forward this report within 48 hours to HR Dept.:

Supervisor: If there is a bodily fluid exposure, also fax this report 274-6620 to Public Health within 24 hours.

County HR/Administration: Must receive original incident report, any additional backup documents as soon as possible.

Human Resources, Employee Leave Admin.: Process as appropriate.

HR Copy To:
□D. Thorpe
□B. Nugent
□J. Schmeiske

WORKPLACE EMPLOYEE INJURY/ILLNESS REPORT FORM

(Please Print)

Tompkins County
Department of
Human Resources
125 East Court Street
Ithaca, New York 14850
www.tompkinscountyny.gov
(607) 274-5526

Today's date:	Date of Incider	Date Employee Leave Administrator Received:								
		BASIC INFO	DRMAT	ON						
Employee Last Name: First: Middle			Initial:	Phone Number: Personal email: () -						
Time My Work Day Began:	□AM □PM	Date of Hire:	/ /	Birth Da	nte: /	/	Gender:	M	F	
Street Address:			Employ	Employee I.D. #.: Job Title:						
		(If known)								
P.O. Box:	City:		State:		ZIP Code:					
Whom did you report the	Date and time you reported it: Did			you receive an Injury Envelope			?			
Incident/Accident to?		☐ Yes ☐ No If no, why?								
		CLAIM INFO			11 110, 1111	<u>, , , , , , , , , , , , , , , , , , , </u>				
Date of Incident/Accident: / / Time of Incid									PM	
Employment Status:	Work Days Scheduled:									
☐ Full-Time ☐ Part-Time	□ Sun □ Mo	n □ Tues □ W	ed □ Th	urs 🗆 Fr	i □ Sat					
		EMPLOYE								
Initial Treatment: ☐ No Medical	Γreatment	inor On-Site Tr	eatment		☐ Minor	Clinic/F	Hospital Trea	ıtment		
☐ Emergency Evaluation By Employer					☐ Future Major Medical/Lost Time					
☐ Hospitalization G				an	Anticipated					
24 Hours										
Did Employee return to work? ☐ Yes ☐ No			T	Date/Time:						
Name of person providing treatme										
Did you seek medical treatment elsewhere? ☐ Yes ☐ No			Date/Time:							
Treatment/Facility Name:			Treatment/Facility Address: IPORTANT **							
All Medical Correspondence	Must Be Submi				125 East Co	ourt St.,	Ithaca, NY	14850		
Have you had a previous work-re	lated injury to the	e same body par	t? □ Yes	□ No	If Yes, Wh	en?				
Nature of Injury (i.e. Laceration,	Burns, Fracture,	Strain, etc.):								
Part of Body (i.e. left arm, right for	oot, head, multipl	le, etc.):								
Cause of Injury (i.e. Motor Vehic	le, Machine, Stra	in or Injury by	lifting, et	c.):						
Incident/Accident Description:										
Officials called to the scene: Sho	eriff State F	Police Itha	ca Police	☐ Fire	Dept.	Ambul	ance 🗆 Oth	er:		
	L	OCATION AN	D WITN	IESSES						
Location Where Incident Occurred:				Is this your normal work location? ☐ Yes ☐ No						
Witnesses Name & Phone #:				Witnesses Name & Phone #:						
Was there a delay between the tin	ne of the incident	/accident and th	ne time of	this repo	rt? □ Yes □	No	If Yes, expl	ain wh	y:	

The following illnesses will be treated as privacy cases on the OSHA/PESH logs:-
 An injury/illness to an intimate body part of the reproductive system; An injury/illness resulting from a sexual assault; Mental illnesses HIV infection, hepatitis, or tuberculosis; Needle stick injuries and cuts from sharp objects that are contaminated with another person's blood or other
potentially infectious material;
For other illness cases: Check this box if you, the employee, have experienced a recordable illness AND you independently and voluntarily request that your name NOT be entered on the DOSH Form SH-900 log.
SUPERVISOR COMPLETE
Did the employee complete the shift? \Box Yes \Box No \Box Did you release the employee to leave early? \Box Yes \Box No
Did you remind employee to follow-up with you the next business day? ☐ Yes ☐ No
Was employee provided with an Injury Envelope? ☐ Yes ☐ No If no, why?
What needs to change in order for this type of incident/accident not to reoccur?
1.
2.
3.
Was a Work Order necessary? ☐ Yes ☐ No Date: Work Order sent to:
Supervisor Signature: Date:
Supervisor Print Name:
By signing below, I verify that the information provided in the report is true, complete and accurate to the best of my knowledge. I understand that any willful omission of and/or falsification is fraudulent and may be punishable to the fullest extent under Section 114a of the NYS Workers Compensation Law. Furthermore, I also understand that completion of this document does <u>not</u> imply or guarantee acceptance of this claim by my employer or insurance carrier.
Employee Signature: Date: / /
Supervisor Signature: Date: / /
Supervisor Print Name:
Office Use Only:Case number from the SH-900 Log: (Transfer the case number from the SH-900 log after you record the case.)

** Due to strict Workers Compensation Guidelines, this form must be forwarded A.S.A.P. to: Sherry Murray, Employee Leave Administrator – HR Dept.**