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.

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

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

WORKPLACE EMPLOYEE INJURY/ILLNESS REPORT FORM

(Please Print)

Today's date:	Date of Incident/Accident:	Date Employee Leave Administrator Received:

BASIC INFORMATION

Employee Last Name: First: Middle Initial:		Phone Number: ( ) / Personal email:	
Time My Work Day Began: ◯AM ◯PM	Date of Hire:	Birth Date:	Gender: M ◯ F ◯
Street Address:		Employee I.D. #.: *(If known)*	Job Title:
P.O. Box:	City:	State:	ZIP Code:
Whom did you report the Incident/Accident to?	Date and time you reported it:	Did you receive an Injury Envelope? ◯Yes ◯No	If no, why?

CLAIM INFORMATION

Date of Incident/Accident:	Time of Incident/Accident: ◯AM ◯PM
Employment Status: ◯Full-Time ◯Part-Time	Work Days Scheduled: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

EMPLOYEE INJURY

Initial Treatment: ◯No Medical Treatment ◯Emergency Evaluation	☐Minor On-Site Treatment By Employer ☐Hospitalization Greater Than 24 Hours	☐Minor Clinic/Hospital Treatment ☐Future Major Medical/Lost Time Anticipated
Did Employee return to work? ◯Yes ◯No		Date/Time: /
Name of person providing treatment on-site:		
Did you seek medical treatment elsewhere? ◯Yes ◯No	Date/Time: /	
Treatment/Facility Name:	Treatment/Facility Address:	

***** IMPORTANT *****
All Medical Correspondence Must Be Submitted Straightaway to: HR Dept.–125 East Court St., Ithaca, NY 14850

Have you had a previous work-related injury to the same body part? ◯Yes ◯No If Yes, When?

Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc.):

Part of Body (i.e. left arm, right foot, head, multiple, etc.):

Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc.):

Incident/Accident Description:

Officials called to the scene: ☐Sheriff ☐State Police ☐Ithaca Police ☐Fire Dept. ☐Ambulance ☐Other:

LOCATION AND WITNESSES

Location Where Incident Occurred:	Is this your normal work location? ◯Yes ◯No
Witnesses Name & Phone #:	Witnesses Name & Phone #:

Was there a delay between the time of the incident/accident and the time of this report? ◯Yes ◯No If Yes, explain why:

The following illnesses will be treated as privacy cases on the OSHA/PESH logs:-

1. An injury/illness to an intimate body part of the reproductive system;
2. An injury/illness resulting from a sexual assault;
3. Mental illnesses
4. HIV infection, hepatitis, or tuberculosis;
5. 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? ◯ Yes ◯ No	Did you release the employee to leave early? ◯ Yes ◯ 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 <u>change</u> 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.****