Cohoes City School District
Employee Accident/Injury/Illness Report Form

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.

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and PESH develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state worker's compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to 12 NYCRR Part 801, PESH recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains. If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____

Title _____

Phone (_____) _____-_____ Date _____/_____/_____

Employee Information:

1) Full name _____

2) Street _____

City _____ State _____ Zip _____

3) Date of birth _____/_____/_____ 4) Date hired _____/_____/_____

5)☐ Male ☐ Female

Physician/Health Care Professional Information:

6) Name of physician or other health care professional _____

_____

7) If treatment was given away from the worksite, where was it given?

Facility_____

Street _____

City _____ State _____ Zip _____

8) Was employee treated in an emergency room?
☐ Yes ☐ No

9) Was employee hospitalized overnight?
☐ Yes ☐ No

Information about the case:

10) Case number from the *Log* _____
(Transfer the case number from the Log after you record the case.)
The Business Office will input the log number.

11) Date of injury or illness _____/_____/_____

12) Time employee began work _____ AM / PM

13) Time of event _____ AM / PM

14) **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. *Examples:* " climbing a ladder while carrying roofing materials" ; " spraying chlorine from hand sprayer."

15) **What happened?** Tell us how the injury occurred. *Examples:* " When ladder slipped on wet floor, worker fell 20 feet" ; " Worker was sprayed with chlorine when gasket broke during replacement."

16) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific that " hurt " , " pain" , or " sore." *Examples:* " strained back"; " chemical burn, hand."

17) **What object or substance directly harmed the employee?** *Examples:* " concrete floor" ; " radial arm saw"; "chlorine."

18) **If the employee died, when did death occur?** Date of death _____/_____/_____

ILLNESS CASES ONLY ☐ Check this box if the employee independently and voluntarily requests that his or her name not be entered on the log. If checked, treat as a privacy concern case.

SH 900.2 (6-02)

Supervisor's Accident/Injury Report

Accident on premises? YES ☐ or NO ☐

Date supervisor first knew of injury: _____

Was employee paid in full for the day? YES ☐ or NO ☐

IF LOSS OF WORK TIME OR MEDICAL BILLS HAVE BEEN INCURRED, SUPERVISOR MUST COMPLETE THE FOLLOWING

Supervisor's investigation: _____

_____

_____

_____

Date employee stopped work: _____ Has employee returned to work: YES ☐ or NO ☐

If yes, on what date did employee return to work? _____

Did employee sign the Medical/Wage consent form? YES ☐ or NO ☐

_____

Signature of Supervisor Date

Report of Witness to Injury **(state exactly what you witnessed)**

_____

_____

_____

_____

_____

_____

_____

FATAL CASES:

Date of Death: _____

Name & address of nearest relative: _____

_____

This form must be completed within 48 hrs of the accident; upon completion forward to Administration Center.

Consent to Develop Medical and Wage Information

_____

"I hereby consent and request that the bearer be permitted to examine and obtain copies of all hospital and medical records of every sort and kind, interview doctors and other attendants regarding all matters relating to examination, diagnosis, care and treatment of myself. I further consent and request that the bearer be permitted to interview and correspond with all employers and former employers regarding all matters relating to my earnings and loss of earnings.

"I am willing that a photostat of this authorization be accepted with the same authority as the original".

_____
Employee Signature

_____
Employee Address

_____

Date _____

07/1982
revised: 04/1995
01/1998
01/2002
01/2003

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