SUNY RF
The Research Foundation for
The State University of New York

Research Foundation Work-Related Employee Injury/Illness Incident Report

EH&S USE ONLY

❒ Recordable ❒ Non-Recordable

Case # _____

❒ Main Campus
❒ Research Foundation
❒ Stony Brook Southampton

Attention: This form contains information relating to employee health and MUST be used in a manner that protects the confidentiality of employees.

SECTION 1. EMPLOYEE INFORMATION: TO BE COMPLETED BY EMPLOYEE AND/OR SUPERVISOR

Last name: _____ First name: _____ Home phone: _____

Home address: _____ City: _____ State: _____ Zip: _____

Date of birth: _____ Gender: ❒ Male ❒ Female Employee's ID # _____

Job title: _____ Date of hire: _____

Employee's department: _____ Work phone: _____

Worker's compensation case/file #: _____ Employee's work shift: _____ ❒ AM ❒ PM

SECTION 2. INJURY/ILLNESS INFORMATION: TO BE COMPLETED BY EMPLOYEE AND/OR SUPERVISOR

Date of injury or illness: _____ Time of injury or illness: _____ ❒ AM ❒ PM

Location of injury or illness (bldg/area): _____

Specific location of injury or illness (room, stairwell, etc.): _____

Did the employee seek medical attention? ❒ Yes ❒ No Did the employee remain on duty? ❒ Yes ❒ No

Date employee stopped work because of this injury or illness: _____ Date employee returned to duty: _____

What was the employee doing JUST BEFORE the accident? Describe the activity, as well as the tools, equipment, or materials the employee was using. Be specific. (Examples "I was standing on a ladder and reaching to repair a leaking valve on a water pipe").

_____

_____

_____

What happened? Tell us how the injury occurred. (Example;"The ladder slipped on wet floor and I fell to the floor 20 feet below landing on my right side").

_____

_____

_____

_____

What was the injury or illness? Tell us the part of the body that was affected and the nature of the injury/illness (how it was affected); be more specific than "hurt", "pain", or "sore" (Example: "Contusion to right shoulder, elbow and knee).

_____

_____

_____

Illness Cases Only	❑	Check this box if the employee independently and voluntarily requests that his or her name **NOT** be entered on the injury/illness log. If this box is checked, treat as a privacy concern case.

Name (Print): _____ Signature: _____ Date: _____

Employee's name: _____ Date of Injury or Illness: _____

SECTION 3. MEDICAL INFORMATION: TO BE COMPLETED BY EMPLOYEE, SUPERVISOR AND/OR MEDICAL PROVIDER

Type/nature of injury:

❒ Amputation ❒ Burn (chemical) ❒ Burn (heat) ❒ Chest pain ❒ Contaminated sharp
❒ Contusion/bruise ❒ Cut/laceration – sutures ❒ Cut/laceration – no sutures ❒ Dislocation ❒ Exposure (Biological)
❒ Exposure (Chemical) ❒ Fracture ❒ Hernia/rupture ❒ Loss of consciousness ❒ Poisoning
❒ Puncture ❒Sprain/strain ❒ Other _____

Type of medical treatment given:

❒ First aid only (i.e., non-prescription strength medications, band-aids, eye patches, immobilization devises, etc.).

❒ X-ray Was a prescription (Rx) prescribed or dispensed? ❒ Yes ❒ No If yes, what medication _____

Date of visit: _____ Time of visit: _____ ❒ AM ❒ PM Body part affected: _____

Medical treatment provided (Print legibly):

_____

_____

_____

_____

Location where treatment was rendered: ❒ Stony Brook ED ❒ Employee Health ❒ Clinic ❒ Other _____

Was the employee hospitalized? ❒ Yes ❒ No If the employee expired, provide date: _____time: _____❒ AM ❒ PM

Medical facility name: _____ Phone: _____

Medical facility address: _____ State:_____ Zip: _____

Are you (the employee) able to return to work ❒ yes ❒ No If no, for how many days: _____

Name (Print): _____Signature: _____Date: _____

SECTION 4. WITNESS STATEMENT/SUPERVISOR INJURY OR ILLNESS INVESTIGATION STATEMENT

Statement of witness:

_____

_____

_____

_____

_____

Name (Print): _____Signature: _____ Date: _____

Supervisor's injury or illness investigation statement: (Provide confirmation of the incident to the extent possible, cause(s) and corrective actions to be taken). Did the supervisor see the injury happen? ❒ Yes ❒ No

_____

_____

_____

_____

_____

_____

_____

_____

Name (Print):_____Signature: _____ Date: _____

NOTE: *This report 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.*

Any employee who files a false report will be subject to the appropriate administrative action including disciplinary action pursuant to the Research Foundation policy.

EMPLOYEE INSTRUCTIONS:

1. Report your injury or illness to your direct supervisor or their designee immediately.

2. Get medical attention if needed. Report to the University Hospital Emergency Department (ED) during off hours or in a life-threatening emergency, and inform them that your injury is work-related.

3. The employee, employee's supervisor, University Hospital Emergency Department (ED) and/or your private medical provider are responsible for completing their section(s) of this report. If you have not received medical attention at this time, this must be noted on the report. NOTE: If medical attention is sought at a later date, documentation must be provided from your private medical provider to Human Resource Services, Research Foundation Benefits z=0751. Human Resource Services, Research Foundation Benefits will notify Environmental Health and Safety (EH&S), z=6200 for OSHA recordkeeping purposes.

4. All occupational injuries or illnesses that occur to employees while on duty must be promptly reported by the employee to fulfill legal reporting requirements under the NYS Workers' Compensation Laws and the Occupational Safety and Health Administration (OSHA).

5. **Complete this report within 24 hours after a work-related injury or illness.** Return the completed report to your supervisor or designee for proper distribution.

6. Supervisors are required to perform an investigation of the injury or illness to determine the root cause(s) and their corrective action(s) to be taken to prevent the incident from being repeated. This information must be provided in the Supervisors Statement section of the report.

7. The Employee Injury/Illness Incident Report must be completed in its entirety and signed legibly.

8. If the employee was exposed to a hazardous material or a bloodborne pathogen (BBP) the employee must be evaluated by the Department of Occupational and Environmental Medicine or the University Hospital Emergency Department (ED); however, the employee is not required to accept treatment. If the injury involves a BBP they must be evaluated within 2 hours of the injury.

9. Notify your direct supervisor or their designee and Human Resources Services, Research Foundation Benefits if your private medical provider extends the off-duty time beyond the time authorized by the Department of Occupational and Environmental Medicine or the University Hospital Emergency Department (ED).

10. If subsequent medical attention is received, documentation must be provided from your private medical provider to Human Resources Services, Research Foundation Benefits. The note from your private medical provider should contain a diagnosis code, prognosis, and estimated date of return.

Important: Promptly completing all of the above steps for reporting your work related injury/illness will ensure payment of all your compensable medical bills and lost work time. In order for Chubb Insurance to evaluate your case for payment of your Workers' Compensation wage replacement benefits and medical bills they need to have a copy of your injury/illness report from your employer and a medical report from a physician indicating your disability is due to your job-related injury.

Distribution:
Human Resources Services, Research Foundation Benefits, 390 Administration Bldg. z=0751 or Fax to 632-2417
Environmental Health & Safety, 110 Suffolk Hall z=6200