



EMPLOYEE INJURY/ILLNESS REPORT

Instructions and Distribution list are on back.

Employees: Check your Work Location:

Hospital

Hospital Off-site (State employees only) (specify: _____)

LISVH

Campus and Research Foundation employees must complete their own respective alternate report form.

Timekeeping/EH&S Use Only

ARS # _____

NYSIF Claim # _____

LT FDO _____ RTW _____

Medical

PESH Recordable Case# _____

PESH Non-Recordable

EMPLOYEE INFORMATION AND INJURY/ILLNESS INFORMATION: To be completed by Employee (or Supervisor, if employee is unable)

Last Name _____ First _____ MI _____ Date of Birth _____ Gender M F

Home Address _____ City _____ State _____ Zip _____

Department _____ Job Title _____

Date of Hire _____ Shift Start Time AM PM End Time AM PM Pass Days _____

Employee ID # _____ Work Phone _____ Cell/Home Phone _____ Police Case Code # _____

Date of accident _____ Time of accident AM PM Event occurred before during after work shift

Exact Location of Injury/Illness (Building/Dept/Floor/Room) _____

What was the employee doing just before the incident occurred? Describe the activity and the tools, equipment, or materials the employee was using. Be specific. (Examples: "Transferring a patient from bed to a chair", "Climbing a ladder while carrying a paint can").

What happened? how did the incident occur and what object or substance directly injured the employee? (Examples: "Patient became unsteady and employee tried to hold them up", "when ladder slipped on wet floor, employee fell 20 feet")

What is the injury/illness? List body part affected and nature of injury/illness. Be more specific than "hurt" or "pain" (Examples: "strained lower back", "chemical burn on right hand).

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, this incident will be treated as a privacy concern case.

Section Completed by (Print) _____ (Signature) _____ Date _____

WITNESS INFORMATION: To be completed by Witness(es)

Name _____ Name _____
Statement _____ Statement _____

Signature _____ Work Phone _____ Signature _____ Work Phone _____

SUPERVISOR INFORMATION: To be completed by Supervisor

Supervisor Statement _____

Planned Corrective Action (action to prevent a reoccurrence): _____

Print Name _____ Signature: _____ Date _____

Date/Time Supervisor notified _____ Work Phone _____

MEDICAL INFORMATION: To be completed by Medical Provider

Location where treatment was rendered Employee Health Stony Brook ED

Other: Medical Provider/Facility name _____ Phone _____

Address _____ State _____ Zip _____

Date of visit _____ Time of visit _____ Body part affected _____

Type of treatment given: First Aid only (i.e., non-prescription strength medications, band-aids, eye patches, immobilization devices)

Medical treatment: Sutures X-ray (Fracture) Prescription Strength Rx prescribed/dispensed

Statement of Findings _____

Education provided: Yes No NA Medical referral made to: _____

Employee can return to work Employee is unable to return to work for _____ days

Was the employee hospitalized? Yes No If employee expired, provide date _____

Name of Medical Provider _____ Signature _____ Date _____

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 applicable collective bargaining unit.

EMPLOYEE INSTRUCTIONS:

1. Report your injury or illness to your direct supervisor or their designee.
2. Get medical attention if needed. Report to Employee Health & Wellness or the Emergency Department (ED) during off hours or in a life-threatening emergency, and inform them that your injury is work-related. Employee Health & Wellness or the ED will complete their portion of this report. If you have not received medical attention at this time, this must be noted on the form. If medical attention is sought at a later date, documentation must be provided from your private medical provider to Timekeeping (z=9121).
3. 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 Public Employee Safety and Health Bureau (PESH).
Complete this report within 24 hours after a work-related injury or illness.
Return this completed report to your supervisor or designee for proper distribution.
4. In addition to completing this report, the employee must call the NYS Accident Reporting System (ARS) at 888-800-0029 to report the incident and receive an incident number.
5. If the employee was exposed to a hazardous material or a bloodborne pathogen (BBP) the employee must be evaluated by Employee Health & Wellness or the 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.
6. Notify your direct supervisor or their designee and Timekeeping if your private medical provider extends the off-duty time beyond the time authorized by Employee Health & Wellness or the ED.
7. If subsequent medical attention is received, documentation must be provided from your private medical provider to Timekeeping. The note from the provider should contain a diagnosis code, prognosis, and estimated date of return.
8. Report any medical equipment incidents to Biomedical Engineering (444-1420).
9. **Keep the original report for your records and provide a copy to your supervisor.**

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 the New York State Insurance Fund to evaluate your case for payment of your Worker's Compensation wage replacement benefits and medical bills they need to have a copy of your injury/illness report from your employer, ARS notification, and a medical report from a physician indicating your disability is due to your job-related injury.

HOSPITAL Employees: Fax completed report to 631-632-2687

(Copies will be distributed to Timekeeping, Environmental Health & Safety, Workers' Compensation and Employee Health & Wellness.)

Distribution List for LISVH Employees Only:

**LISVH Human Resources, z=9500
Environmental Health & Safety, z=8017**