Employee Injury & Illness Incident Report

County of Westchester
148 Martine Avenue, Room 730
White Plains, NY 10601

All sections of the form must be completed. Please contact the Benefits Office with any questions 914-995-4834.

Local Case ID # _____ (To be assigned by the Finance Dept.)

EMPLOYEE'S PERSONAL INFORMATION

Name _____ Date of Birth: _____
Mailing Address_____
Social Security Number_____Phone Number _____ Male_____Female_____

EMPLOYEE'S INJURY OR ILLNESS Date of Injury _____
Time of day employee began work on date of injury_____AM/PM Time of Injury _____AM/PM
Has the employee given you notice of injury/illness Yes_____ No_____
If yes, notice was given to_____Orally___In Writing ___Date of Notice _____
If available, attach a copy of the employee's written notice and medical notes, and the employer's incident report.
Where did the injury/illness happen? _____
_____
Was this location where the employee normally worked? Yes____No____ If no, why was the employee there?
_____
Employee's Supervisor_____ Did supervisor see injury happen? Yes____No____Unknown____
Did anyone else see the injury happen? Yes _____No___Unknown_____If yes, give name(s)_____
_____
What was the employee doing when he/she was injured or became ill? Be Specific_____
_____
_____
How did the injury/illness occur? Be Specific _____
_____
_____
Explain fully the nature of the employee's injury/illness; list body parts affected. Be Specific_____
_____
_____
_____
Was an object, e.g. forklift, hammer, acid, involved in the injury/illness Yes_____No_____
If yes, what was it?_____
Was the injury the result of the use or operation of a licensed motor vehicle? Yes_____No_____ If yes,
Employee's vehicle_____Employer vehicle_____Other vehicle_____License plate number_____
If employer's vehicle was involved, give name and address of your motor vehicle insurance carrier_____
_____

Did the injury/illness result in the employee's death? Yes_____No_____ If yes, date of death_____

Name and address of nearest relative: _____
_____

MEDICAL TREATMENT

What was the date of the employee's first treatment?_____None Received_____Unknown____
Where did the employee receive first medical treatment for this injury/illness? On Site_____Doctor's Office_____
Emergency Room _____Clinic/Hospital/Urgent Care _____Hospital Stay over 24 Hours_____Unknown____
Who treated the employee and where?_____
Is the employee still being treated for this injury/illness Yes__No___Unknown____ If yes, name and address of Treating doctor(s):_____

To your knowledge, did the employee have another work-related injury to the same body part or a similar illness while working for you? Yes_____No___If yes, name the doctor(s) who treated the previous injuries/illnesses if known:

RETURN TO WORK

Did the employee stop work because of his/her injury/illness? Yes_____No___ If yes, on what date?_____
Has the employee returned to work? Yes___No___
If yes, on what date_____Regular Duty_____Limited Duty_____
If the employee has returned to limited duty, what are his/her average gross earnings per week?_____

EMPLOYEE'S WORK INFORMATION ON THE DATE OF THE INJURY OR ILLNESS:

Date the employee was hired _____What was the employee's job title?_____
What types of activities did the employee normally perform at work? Attach a job description if available.

EMPLOYEE'S PAYROLL INFORMATION ON THE DATE OF THE INJURY OR ILLNESS:

Employee's gross pay in an average week?_____
Did the employee receive lodging or tips in addition to pay? Yes_____No_____
Employee's job was (Check One) Full Time____Part Time____Seasonal_____Volunteer____Other_____
Which days of the week did the employee usually work? Mon___Tues___Wed___Thurs___Fri___Sat___ Sun_____
Was the employee paid for a full day on the day of the injury/illness? Yes_____No____
Did you continue to pay the employee after the injury/illness, (sick leave, vacation, disability, regular salary?
Yes_____No_____

ADDITIONAL INFORMATION:

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who knowingly makes a false statement or representation as to a material fact in the course of reporting, investigation of or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit shall be guilty of a crime and subject to substantial fines and imprisonment.

The above information is true to the best of my knowledge and belief.

If prepared by the employer:

Signature of Person Preparing Form_____Date_____
Print Name_____Title _____
Phone Number_____

If prepared by a third party on behalf of the employer:

Signature of Person Preparing Form_____Date_____
Print Name_____Title _____
Phone Number_____
Company Name and Address:_____
Name and phone number of person who provided information necessary to prepare this form: _____

Finance Dept. Benefits Office	Completed by	Date