



# 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: \_\_\_\_\_