

# GENESEO

## Accident Report

ARS # 1-888-800-0029

### Part 1

Name:		ARS#: 00	Department:
Date of Hire:	Date of Birth:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input checked="" type="checkbox"/> X	
Address:			Please Check One: <input type="checkbox"/> CSEA <input type="checkbox"/> PEF <input type="checkbox"/> UUP <input type="checkbox"/> MC <input type="checkbox"/> NYSCOPBA <input type="checkbox"/> PBANYS
Home Phone:	Cell Phone:		
Date of Accident:	Time of Accident:	Date of Report:	Time Shift Began:
Pass Days: <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat	Job Title:		
First person you told of accident:		Provide name(s) of any witness(es):	
Location of Occurrence:		Was this an area you were authorized to be in? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Describe in detail your injury and what you were doing when the injury/illness occurred:

What tools, equipment, objects or substances were involved?

Was Medical Assistance Rendered?  No  Yes – by whom & when?  First aid by Staff  Lauderdale Health Center  GFR  
 Did you go to the Emergency Room?  No  Yes  
 Were you admitted to the Hospital?  No  Yes

Treating Healthcare Provider Info for injury– Name Address Phone #

### Part 2

Supervisor (Print Name):	Date and time you were notified of injury/illness: Date: _____ Time: _____
Did employee continue working? <input type="checkbox"/> No <input type="checkbox"/> Yes If NO, date left work:	First full date of absence: Date employee returned:

Supervisor Comments:

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### FOR HR USE

Med <input type="checkbox"/> No <input type="checkbox"/> Yes	Lost Time <input type="checkbox"/> No <input type="checkbox"/> Yes	ARS	Pesh: <input type="checkbox"/> Yes <input type="checkbox"/> No	
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### Part 3

Please check all that apply with respect to your injury/illness. You should have at least **one box checked** in each column

Body Part(s)	Nature of Injury/Illness	Event(s)/Cause(s)	Source(s)/Exposure(s)
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Abrasions/scrapes/scratch	<input type="checkbox"/> Alleged Assault	<input type="checkbox"/> Animal
<input type="checkbox"/> Ankle <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Allergic Reaction	<input type="checkbox"/> Alleged Harassment	<input type="checkbox"/> Bacteria/Virus/Fungus
<input type="checkbox"/> Arm <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Bite(s)/Sting(s)	<input type="checkbox"/> Bending/Stooping	<input type="checkbox"/> Bed/Stand
<input type="checkbox"/> Back, Inc Spine	<input type="checkbox"/> Breathing Difficulty	<input type="checkbox"/> Climbing	<input type="checkbox"/> Blood/Body Fluids
<input type="checkbox"/> Body Systems	<input type="checkbox"/> Burn(s)	<input type="checkbox"/> Collapse	<input type="checkbox"/> Body Movement/Motion
<input type="checkbox"/> Breast <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Collided with	<input type="checkbox"/> Broken Glass/ Sharp Object
<input type="checkbox"/> Buttock(s)	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Computer Use	<input type="checkbox"/> Buildings and Premises
<input type="checkbox"/> Chest	<input type="checkbox"/> Contusion(s)/Bruise(s)	<input type="checkbox"/> Construction	<input type="checkbox"/> Carts/Dollies
<input type="checkbox"/> Ear <input checked="" type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Crush Injury	<input type="checkbox"/> Contact with	<input type="checkbox"/> Chemical(s) Specify: _____
<input type="checkbox"/> Elbow <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Repetitive Strain/Sprain	<input type="checkbox"/> Fall	<input type="checkbox"/> Cleaning Agent Specify: _____
<input type="checkbox"/> Eye <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Death	<input type="checkbox"/> Grounds work	<input type="checkbox"/> Computer
<input type="checkbox"/> Face	<input type="checkbox"/> Dislocation(s)	<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Co Worker
<input type="checkbox"/> Finger(s) <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Ingestion	<input type="checkbox"/> Dust/Airborne Particles
<input type="checkbox"/> Foot <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Electric Shock	<input type="checkbox"/> Inhalation	<input type="checkbox"/> Electricity
<input type="checkbox"/> Groin	<input type="checkbox"/> Exposure(s)	<input type="checkbox"/> Kneeling	<input type="checkbox"/> Elevator
<input type="checkbox"/> Hand <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Lifting	<input type="checkbox"/> Equipment Specify: _____
<input type="checkbox"/> Head	<input type="checkbox"/> Broken Bone	<input type="checkbox"/> Material Handling	<input type="checkbox"/> Explosion and/or Fire
<input type="checkbox"/> Hip <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Headache	<input type="checkbox"/> Needle Stick	<input type="checkbox"/> Falling Object(s)
<input type="checkbox"/> Internal Organ(s)	<input type="checkbox"/> Hearing Disorder/loss	<input type="checkbox"/> Overexertion	<input type="checkbox"/> Floor
<input type="checkbox"/> Knee <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Hernia	<input type="checkbox"/> Overextension	<input type="checkbox"/> Friction
<input type="checkbox"/> Leg <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Infectious/Parasitic Disease	<input type="checkbox"/> Pinched	<input type="checkbox"/> Fume(s)/Noxious Odor(s)
<input type="checkbox"/> Lip(s)	<input type="checkbox"/> Internal Organ Injury	<input type="checkbox"/> Pulling	<input type="checkbox"/> Gas(es)
<input type="checkbox"/> Lung <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Laceration(s)/Cut(s)	<input type="checkbox"/> Pushing	<input type="checkbox"/> Ground
<input type="checkbox"/> Mouth	<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Reaching	<input type="checkbox"/> Hand Tool(s)
<input type="checkbox"/> Neck	<input type="checkbox"/> Mental Disorder/Stress/Anxiety	<input type="checkbox"/> Repetitive Work	<input type="checkbox"/> Hot or Cold Temperature
<input type="checkbox"/> Nose <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Muscle/Tendon/Ligament/Joint/Inj	<input type="checkbox"/> Restraining Person	<input type="checkbox"/> Insect(s)
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Slip/Trip/Loss of Bal w/o Fall	<input type="checkbox"/> Instrument(s)
<input type="checkbox"/> Ribs <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> No Apparent Injury	<input type="checkbox"/> Spill	<input type="checkbox"/> Lighting
<input type="checkbox"/> Shoulder <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Spray/Splash	<input type="checkbox"/> Loud Noise
<input type="checkbox"/> Skin	<input type="checkbox"/> Pain	<input type="checkbox"/> Struck Against	<input type="checkbox"/> Motor Vehicle
<input type="checkbox"/> Stomach	<input type="checkbox"/> Paralysis/Weakness	<input type="checkbox"/> Struck By	<input type="checkbox"/> Office Equipment
<input type="checkbox"/> Tailbone	<input type="checkbox"/> Poisoning		<input type="checkbox"/> Organic Compounds
<input type="checkbox"/> Teeth	<input type="checkbox"/> Puncture(s)		<input type="checkbox"/> Paints/Solvents
<input type="checkbox"/> Thigh <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Resp. Distress/ Shortness of Breath		<input type="checkbox"/> Parking Garage
<input type="checkbox"/> Thumb <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Splinter(s)		<input type="checkbox"/> Parking Lot
<input type="checkbox"/> Toe(s) <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Sprain(s)/Strain(s)		<input type="checkbox"/> Radiation
<input type="checkbox"/> Tongue	<input type="checkbox"/> Swelling		<input type="checkbox"/> Scaffold
<input type="checkbox"/> Wrist <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Visual Disturbance(s)		<input type="checkbox"/> Sharp Object Specify: _____
			<input type="checkbox"/> Sidewalk/Curb/Pavement
			<input type="checkbox"/> Snow/Ice
			<input type="checkbox"/> Stairwell
			<input type="checkbox"/> Steam
			<input type="checkbox"/> Student
			<input type="checkbox"/> Vibration
			<input type="checkbox"/> Visitor
			<input type="checkbox"/> Volunteer
			<input type="checkbox"/> Water/Liquid
			<input type="checkbox"/> Window/Door

Other - List:

Other - List:

Other - List:

Other - List:

Signature of Injured Person: \_\_\_\_\_ Date: \_\_\_\_\_

# Essential Responsibilities for Workers Compensation Injuries/Illnesses

## Employee

1. The employee must report the Injury/Illness to **1-888-800-0029** within 24 hours of the Injury/Illness. The NYS Accident Reporting System (ARS) electronically assigns numbers to the claim for easier processing. This is also called the incident number.
2. Employee must complete **Part 1 and Part 3** of the Injury/Illness Report with as much information as possible regarding the injury or illness (include the ARS # on the form).
3. The form must be signed by the employee and their supervisor.
4. The form must be submitted to Human Resources to get the claim started.
5. Employees must notify their physician that this is work related and any bills need to be sent to SIF (State Insurance Fund).
6. Inform your supervisor/Human Resources of first Injury/Illness date and to follow up with any additional lost time or medical treatment related to the injury.
7. RTW documentation must be sent to Human Resources 48 hours prior to date for review/approval.

## Supervisor(s)

1. Complete your portion of the Injury/Illness report and verify that the form is completed in full, including signatures.
2. Keep Human Resources informed of any correspondence with employee.
3. Confirm with Human Resources when the employee intends to return to work.

\*\* Facilities Services employees should forward the completed form to Facilities Secretary first.