GENESEO

ACCIDENT REPORT FORM

(OTHER THAN MOTOR VEHICLE ACCIDENTS)

PLEASE PRINT

Part 1: General Information to be completed by or on behalf of the injured/ill party:

Reporter of Accident: □Injured/Ill Party □Faculty/Staff □Other (specify) _____

What is the injured/ill party's status: □Faculty/Staff □Student Employee □Student
□Vendor □Visitor □Other (specify) _____

Name of Injured/Ill Party: _____

Date of Birth: ____ /____/_____ Gender: □Female □Male

Home Address: _____ Home Telephone: _____
_____ Cell Telephone: _____

Part 2: Information to be completed by or on behalf of injured/ill party:

Date of report: ____ /____ /____ Date of accident: ____ /____ /____ Time of accident: _____

Location of occurrence: _____

Was the injured/ill party in an area they were authorized to be in? □Yes □No □Unknown

Did the injured/ill party require medical attention? □Yes □No If yes, when: _____

Was medical assistance rendered? □Yes □No If yes, by whom?
□First aid by staff □Lauderdale Health Center staff □Hospital
□GFR □Other _____ □Ambulance: _____

Name & address of hospital (if applicable):

_____

Name & address of attending physician (if applicable):

_____

Was treatment provided in an emergency room? □Yes □No

Was injured/ill party hospitalized overnight? □Yes □No

NARRATIVE: (Give a brief description of who, what, when, where, how, etc.)

_____
_____
_____
_____
_____

Were there witnesses to the incident? □Yes □No

Name, address, telephone number of witnesses:

_____ _____
_____ _____
_____ _____

Statement of witness (if more than one, please attach additional statements):

_____

_____
_____
_____

_____ _____
Signature Date

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Part 3: To be completed by or on behalf of an injured EMPLOYEE ONLY

NYS ARS Incident # (call 1-888-800-0029): _____

Job title: _____ Bargaining unit: _____
Date of hire: _____ Work telephone: _____
Campus work location: _____ Office/Department Name: _____
Normal work hours: _____ Time shift began: _____
Employee remained on duty after accident/injury? □Yes □No Pass days: _____
Date of first full day of absence: _____ Has employee returned to work? □Yes □No
If yes, date: _____ Does the employee have restricted duties? □Yes □No
Describe the injury or illness. Include a description of the exact body part(s) and location(s) affected, i.e. right, left, upper, middle, lower: _____
_____
_____
_____
Was the accident: □Job related □Academic □Other _____

What was the employee doing just before the incident occurred? Describe the activity, as well as any tools, equipment (including personal protective equipment), or material(s) the employee was using. Be specific (attach additional pages if necessary): _____
_____
_____
_____
What happened? How did the accident or exposure occur? (attach additional pages if necessary):
_____
_____
_____
What object or substance directly harmed the individual? *Examples: concrete floor, radial arm saw, chlorine.* In case of strains - identify the object that caused strain. *Examples: lifting, pulling, etc.*
_____
_____
_____

_____ _____
Injured employees signature (if able to sign) **Date**

<u>To be completed by injured employee's supervisor</u>:

Supervisor notified: □Yes □No Date notified: ____ /____/_____ Time: _____
Supervisor Statement (attach additional page if necessary):
_____
_____
_____
Supervisor Name (PRINT): _____

_____ _____
Supervisor's Signature **Date**

☐ SUNY Counsel's Office
☐ Dormitory Authority