GENESEO

Accident Report

ARS # 1-888-800-0029

Part 1				
Name:		ARS#: 00		Department:
Date of Hire:	Date of Birth:	Gender: ☐Female ☐Male ☐ X		
Address:				Please Check One: ☐ CSEA ☐ PEF ☐ UUP ☐ MC ☐ NYSCOPBA ☐ PBANYS
Home Phone:		Cell Phone:		
Date of Accident:	Time of Accident:	Date of Report:	Time Shift Began:	
Pass Days: ☐Sun ☐Mon ☐Tue ☐Wed ☐Thur ☐Fri ☐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? ☐ Yes ☐ 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? ☐ No ☐ Yes If NO, date left work:	First full date of absence: Date employee returned:

Supervisor Comments:

Supervisor Signature: Date:

FOR HR USE				
Med ☐No ☐ Yes	Lost Time ☐No ☐Yes	ARS	Pesh: ☐Yes ☐ No	

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)

- ☐ Abdomen
- ☐ Ankle ☐ Left ☐ Right
- ☐ Arm ☐ Left ☐ Right
- ☐ Back, Inc Spine
- ☐ Body Systems
- ☐ Breast ☐Left ☐ Right
- ☐ Buttock(s)
- ☐ Chest
- ☐ Ear Left ☐ Right
- ☐ Elbow Left ☐ Right
- ☐ Eye ☐ Left ☐ Right
- ☐ Face
- ☐ Finger(s) ☐ Left ☐ Right
- ☐ Foot ☐ Left ☐ Right
- ☐ Groin
- ☐ Hand ☐ Left ☐ Right
- ☐ Head
- ☐ Hip ☐ Left ☐ Right
- ☐ Internal Organ(s)
- ☐ Knee ☐ Left ☐ Right
- ☐ Leg ☐ Left ☐ Right
- ☐ Lip(s)
- ☐ Lung ☐ Left ☐ Right
- ☐ Mouth
- ☐ Neck
- ☐ Nose ☐ Left ☐ Right
- ☐ Pelvis
- ☐ Ribs ☐ Left ☐ Right
- ☐ Shoulder ☐ Left ☐ Right
- ☐ Skin
- ☐ Stomach
- ☐ Tailbone
- ☐ Teeth
- ☐ Thigh ☐ Left ☐ Right
- ☐ Thumb ☐ Left ☐ Right
- ☐ Toe(s) ☐ Left ☐ Right
- ☐ Tongue
- ☐ Wrist ☐ Left ☐ Right

☐ Other - List:

Nature of Injury/Illness

- ☐ Abrasions/scrapes/scratch
- ☐ Allergic Reaction
- ☐ Bite(s)/Sting(s)
- ☐ Breathing Difficulty
- ☐ Burn(s)
- ☐ Chest Pain
- ☐ Head Injury
- ☐ Contusion(s)/Bruise(s)
- ☐ Crush Injury
- ☐ Repetitive Strain/Sprain
- ☐ Death
- ☐ Dislocation(s)
- ☐ Dizziness
- ☐ Electric Shock
- ☐ Exposure(s)
- ☐ Foreign Body
- ☐ Broken Bone
- ☐ Headache
- ☐ Hearing Disorder/loss
- ☐ Hernia
- ☐ Infectious/Parasitic Disease
- ☐ Internal Organ Injury
- ☐ Laceration(s)/Cut(s)
- ☐ Loss of Consciousness
- ☐ Mental Disorder/Stress/Anxiety
- ☐ Muscle/Tendon/Ligament/Joint/Inj
- ☐ Nausea/Vomiting
- ☐ No Apparent Injury
- ☐ Numbness/Tingling
- ☐ Pain
- ☐ Paralysis/Weakness
- ☐ Poisoning
- ☐ Puncture(s)
- ☐ Resp. Distress/ Shortness of Breath
- ☐ Splinter(s)
- ☐ Sprain(s)/Strain(s)
- ☐ Swelling
- ☐ Visual Disturbance(s)

☐ Other - List:

Event(s)/Cause(s)

- ☐ Alleged Assault
- ☐ Alleged Harassment
- ☐ Bending/Stooping
- ☐ Climbing
- ☐ Collapse
- ☐ Collided with
- ☐ Computer Use
- ☐ Construction
- ☐ Contact with
- ☐ Fall
- ☐ Grounds work
- ☐ Housekeeping
- ☐ Ingestion
- ☐ Inhalation
- ☐ Kneeling
- ☐ Lifting
- ☐ Material Handling
- ☐ Needle Stick
- ☐ Overexertion
- ☐ Overextension
- ☐ Pinched
- ☐ Pulling
- ☐ Pushing
- ☐ Reaching
- ☐ Repetitive Work
- ☐ Restraining Person
- ☐ Slip/Trip/Loss of Bal w/o Fall
- ☐ Spill
- ☐ Spray/Splash
- ☐ Struck Against
- ☐ Struck By

☐ Other - List:

Source(s)/Exposure(s)

- ☐ Animal
- ☐ Bacteria/Virus/Fungus
- ☐ Bed/Stand
- ☐ Blood/Body Fluids
- ☐ Body Movement/Motion
- ☐ Broken Glass/ Sharp Object
- ☐ Buildings and Premises
- ☐ Carts/Dollies
- ☐ Chemical(s) Specify:_____
- ☐ Cleaning Agent Specify:____
- ☐ Computer
- ☐ Co Worker
- ☐ Dust/Airborne Particles
- ☐ Electricity
- ☐ Elevator
- ☐ Equipment Specify:_____
- ☐ Explosion and/or Fire
- ☐ Falling Object(s)
- ☐ Floor
- ☐ Friction
- ☐ Fume(s)/Noxious Odor(s)
- ☐ Gas(es)
- ☐ Ground
- ☐ Hand Tool(s)
- ☐ Hot or Cold Temperature
- ☐ Insect(s)
- ☐ Instrument(s)
- ☐ Lighting
- ☐ Loud Noise
- ☐ Motor Vehicle
- ☐ Office Equipment
- ☐ Organic Compounds
- ☐ Paints/Solvents
- ☐ Parking Garage
- ☐ Parking Lot
- ☐ Radiation
- ☐ Scaffold
- ☐ Sharp Object Specify:
- ☐ Sidewalk/Curb/Pavement
- ☐ Snow/Ice
- ☐ Stairwell
- ☐ Steam
- ☐ Student
- ☐ Vibration
- ☐ Visitor
- ☐ Volunteer
- ☐ Water/Liquid
- ☐ Window/Door

☐ 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.