ROCHESTER INSTITUTE OF TECHNOLOGY
Workers’ Compensation Accident/Injury/Illness Report Form

The injured worker and supervisor must complete and file this report with the Human Resources Department within 24 hours of any accident or injury.

Date Filed: ______________ Time Filed: _________ a.m. _________ p.m.

SECTION I: EMPLOYEE PERSONAL INFORMATION
Important Note: RIT will also provide the Social Security Number and date of birth as required by the New York State Workers’ Compensation Board.

Name: ___________________________________________ Employee #: ____________________

Department Name: __________________________________ Department #: ___________________

RIT E-Mail: _________________________________________ RIT Phone #: __________________

Home Address: _____________________________________ Home/Cell Phone #: ______________

Job/Occupation Title: ___________________________________________________________________

Supervisor Name: __________________________________ Supervisor Phone #: ______________

SECTION II: EMPLOYEE’S STATEMENT OF ACCIDENT/INJURY/ILLNESS

Date of Incident: ______________ Time of Incident: ________ a.m. ________ p.m.

Time Employee’s Work Shift Began: ________ a.m. ________ p.m.

Employee’s Work Week (days and time scheduled to work): __________________________________

Location of Incident (be specific): _________________________________________________________

How did the injury/illness occur? __________________________________________________________
____________________________________________________________________________________

What part of the body was affected and how was it affected? __________________________________
____________________________________________________________________________________

Type of Injury/Illness (i.e. cut, sprain, burn, repetitive): ______________________________________

If injury was caused by an object or substance, please identify: ________________________________

If you experienced pain with this injury, was the pain sudden or gradual in onset?
____________________________________________________________________________________

Have you ever received medical care for a similar condition? If yes, please explain:
____________________________________________________________________________________
What were you doing right before the incident occurred? (provide specific details)

Date and time you reported your injury: 

To whom did you report the incident?

How did you report the incident?

Were there any witnesses to the incident?  No  Yes, list names below

names of all witnesses: 

Are you currently self-employed or do you have a job at another company?  No  Yes

Name and address of company: 
Describe job: 

I affirm that all statements on this report are true and complete to the best of my knowledge. I understand that if I knowingly file a claim containing false or misleading information that I will be in violation of RIT policy which may result in discipline up to and including termination of employment.

Employee Signature  Date

EMPLOYEE MEDICAL RELEASE STATEMENT
I hereby authorize the release of any medical information, diagnostic reports, etc. to RIT’s designated Preferred Provider Organization representative and Third Party Administrator (Key Insurance & Benefits Services) relevant to the work related injury in this report. Unless otherwise noted, this medical release will be applicable for the duration of all medical treatment related to my work injury/illness. I understand I may terminate this release by submitting written notice to the PPO/TPA.

Employee Signature  Date

SECTION III: ACCIDENT INVESTIGATION (to be completed by the supervisor)

Root Cause of Incident:  Operator Failure*  Equipment Failure  Environmental Hazard  Lack of Training  Other

Explanation in detail: 

*Operator Failure may include: Did not follow safety procedures Insufficient communication between co-workers Employee carelessness

When were you notified of the incident? Date:  Time: a.m.  p.m.
Who notified you and how were you notified? _______________________________________________

What corrective measures have/or will be taken to prevent recurrence? (e.g., employee safety counseling or removal of hazard): ________________________________________________________________

Will disciplinary action be taken?  □ No  □ Yes, identify action: ______________________________

What safety training has the employee received that is applicable to the injury that occurred?

Was personal protective equipment in use at time of incident?  □ No  □ Yes, explain below

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**SECTION IV: MEDICAL TREATMENT INFORMATION (to be completed by the supervisor)**

RIT participates in a Workers’ Compensation Preferred Provider Organization (PPO) that requires all medical treatment be provided through the PPO for a minimum of 30 days following the first day of treatment. In the event the employee needs to seek medical treatment, please contact RIT’s Workers’ Compensation Case Manager, Pamela O’Leary, Key Insurance & Benefits Services at 770-1600/V – select option #1 or call the NYS Relay Service 1-800-662-1220 (tty/vco/hco). After Hours: call Rochester Immediate Care at 444-0058 (2685 E. Henrietta Rd) or 225-5252 (2685 W. Ridge Rd) weeknights until 10:00 pm and weekends between 9:00 am -8:00 pm or Eastside Urgent Care at 388-5280 (2226 Penfield Rd) weeknights until 10:00 pm and weekends between 9:00 am – 6:00 pm.

Did employee receive medical treatment?  □ No  □ Yes

Did manager/employee notify RIT’s Case Manager?  □ No  □ Yes, provide details

Date of Contact: ___________________      Time of Contact: ____________________

Was employee treated in an emergency room?  □ No  □ Yes

Name of doctor or hospital: ________________________________________________________

Did employee lose time from work (explain below)?  □ No  □ Yes

Did the incident result in work restrictions (explain below)?  □ No  □ Yes

_____________________________________________________ ______________________________
Supervisor Signature Date

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Employees who experience work related injuries may be required to meet with RIT Human Resources to discuss the incident and the events surrounding the incident. Reasons for this meeting include, but are not limited to the following:

- Report filed and or received later than 24 hours following the incident.
- Accident report is not completed in full by employee and supervisor.
- Employee has repeated incidents and injuries on file with RIT.
- There are no witnesses to confirm the injury.