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 (Future Comp/USI) 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

_____

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 Nurse Case Manager, Ann Lynch (Future Comp) at 860-652-1079/V or call the NYS Relay Service 1-800-662-1220 (tty/vco/hco). After Hours: weeknights until 9:00 pm and weekends between 9:00 am – 7:00 pm, call Lifetime Health After Hours at 338-1200/V or 336-4894/TTY.

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

_____

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.***

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