



The Research Foundation for  
The State University of New York

**Research Foundation  
Work-Related  
Employee Injury/Illness Incident Report**

**EH&S USE ONLY**

Recordable       Non-Recordable

Case # \_\_\_\_\_

- Main Campus
- Research Foundation
- Stony Brook Southampton

**Attention:** This form contains information relating to employee health and MUST be used in a manner that protects the confidentiality of employees.

**SECTION 1. EMPLOYEE INFORMATION: TO BE COMPLETED BY EMPLOYEE AND/OR SUPERVISOR**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Home phone: \_\_\_\_\_  
 Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Gender:  Male  Female Employee's ID # \_\_\_\_\_  
 Job title: \_\_\_\_\_ Date of hire: \_\_\_\_\_  
 Employee's department: \_\_\_\_\_ Work phone: \_\_\_\_\_  
 Worker's compensation case/file #: \_\_\_\_\_ Employee's work shift: \_\_\_\_\_  AM  PM

**SECTION 2. INJURY/ILLNESS INFORMATION: TO BE COMPLETED BY EMPLOYEE AND/OR SUPERVISOR**

Date of injury or illness: \_\_\_\_\_ Time of injury or illness: \_\_\_\_\_  AM  PM  
 Location of injury or illness (bldg/area): \_\_\_\_\_  
 Specific location of injury or illness (room, stairwell, etc.): \_\_\_\_\_  
 Did the employee seek medical attention?  Yes  No Did the employee remain on duty?  Yes  No  
 Date employee stopped work because of this injury or illness: \_\_\_\_\_ Date employee returned to duty: \_\_\_\_\_

**What was the employee doing JUST BEFORE the accident?** Describe the activity, as well as the tools, equipment, or materials the employee was using. Be specific. (Examples "I was standing on a ladder and reaching to repair a leaking valve on a water pipe").

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**What happened?** Tell us how the injury occurred. (Example;"The ladder slipped on wet floor and I fell to the floor 20 feet below landing on my right side").

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**What was the injury or illness?** Tell us the part of the body that was affected and the nature of the injury/illness (how it was affected); be more specific than "hurt", "pain", or "sore" (Example: "Contusion to right shoulder, elbow and knee).

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>Illness Cases Only</b>	<input type="checkbox"/>	Check this box if the employee independently and voluntarily requests that his or her name <b>NOT</b> be entered on the injury/illness log. If this box is checked, treat as a privacy concern case.
---------------------------	--------------------------	--

Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee's name: \_\_\_\_\_ Date of Injury or Illness: \_\_\_\_\_

**SECTION 3. MEDICAL INFORMATION: TO BE COMPLETED BY EMPLOYEE, SUPERVISOR AND/OR MEDICAL PROVIDER**

**Type/nature of injury:**

- Amputation       Burn (chemical)       Burn (heat)       Chest pain       Contaminated sharp
- Contusion/bruise       Cut/laceration – sutures       Cut/laceration – no sutures       Dislocation       Exposure (Biological)
- Exposure (Chemical)       Fracture       Hernia/rupture       Loss of consciousness       Poisoning
- Puncture       Sprain/strain       Other \_\_\_\_\_

**Type of medical treatment given:**

- First aid only (i.e., non-prescription strength medications, band-aids, eye patches, immobilization devices, etc.).
- X-ray      Was a prescription (Rx) prescribed or dispensed?     Yes     No    If yes, what medication \_\_\_\_\_

Date of visit: \_\_\_\_\_ Time of visit: \_\_\_\_\_  AM  PM    Body part affected: \_\_\_\_\_

Medical treatment provided (Print legibly):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Location where treatment was rendered:     Stony Brook ED     Employee Health     Clinic     Other \_\_\_\_\_

Was the employee hospitalized?     Yes     No    If the employee expired, provide date: \_\_\_\_\_ time: \_\_\_\_\_  AM  PM

Medical facility name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical facility address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Are you (the employee) able to return to work     yes     No                      If no, for how many days: \_\_\_\_\_

Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 4. WITNESS STATEMENT/SUPERVISOR INJURY OR ILLNESS INVESTIGATION STATEMENT**

**Statement of witness:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Supervisor's injury or illness investigation statement:** (Provide confirmation of the incident to the extent possible, cause(s) and corrective actions to be taken). Did the supervisor see the injury happen?     Yes     No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** This report contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Any employee who files a false report will be subject to the appropriate administrative action including disciplinary action pursuant to the Research Foundation policy.

#### **EMPLOYEE INSTRUCTIONS:**

1. Report your injury or illness to your direct supervisor or their designee immediately.
2. Get medical attention if needed. Report to the University Hospital Emergency Department (ED) during off hours or in a life-threatening emergency, and inform them that your injury is work-related.
3. The employee, employee's supervisor, University Hospital Emergency Department (ED) and/or your private medical provider are responsible for completing their section(s) of this report. If you have not received medical attention at this time, this must be noted on the report. NOTE: If medical attention is sought at a later date, documentation must be provided from your private medical provider to Human Resource Services, Research Foundation Benefits z=0751. Human Resource Services, Research Foundation Benefits will notify Environmental Health and Safety (EH&S), z=6200 for OSHA recordkeeping purposes.
4. All occupational injuries or illnesses that occur to employees while on duty must be promptly reported by the employee to fulfill legal reporting requirements under the NYS Workers' Compensation Laws and the Occupational Safety and Health Administration (OSHA).
5. **Complete this report within 24 hours after a work-related injury or illness.** Return the completed report to your supervisor or designee for proper distribution.
6. Supervisors are required to perform an investigation of the injury or illness to determine the root cause(s) and their corrective action(s) to be taken to prevent the incident from being repeated. This information must be provided in the Supervisors Statement section of the report.
7. The Employee Injury/Illness Incident Report must be completed in its entirety and signed legibly.
8. If the employee was exposed to a hazardous material or a bloodborne pathogen (BBP) the employee must be evaluated by the Department of Occupational and Environmental Medicine or the University Hospital Emergency Department (ED); however, the employee is not required to accept treatment. If the injury involves a BBP they must be evaluated within 2 hours of the injury.
9. Notify your direct supervisor or their designee and Human Resources Services, Research Foundation Benefits if your private medical provider extends the off-duty time beyond the time authorized by the Department of Occupational and Environmental Medicine or the University Hospital Emergency Department (ED).
10. If subsequent medical attention is received, documentation must be provided from your private medical provider to Human Resources Services, Research Foundation Benefits. The note from your private medical provider should contain a diagnosis code, prognosis, and estimated date of return.

**Important:** Promptly completing all of the above steps for reporting your work related injury/illness will ensure payment of all your compensable medical bills and lost work time. In order for Chubb Insurance to evaluate your case for payment of your Workers' Compensation wage replacement benefits and medical bills they need to have a copy of your injury/illness report from your employer and a medical report from a physician indicating your disability is due to your job-related injury.

#### **Distribution:**

Human Resources Services, Research Foundation Benefits, 390 Administration Bldg. z=0751 or Fax to 632-2417  
Environmental Health & Safety, 110 Suffolk Hall z=6200