Quick Facts for Workers' Compensation

- If an employee becomes injured on the job
  - Employee must report the incident to their supervisor
  - Employee must complete an accident report- signed by the supervisor and submit form to Donna Magill ASAP.
  - Donna Magill (in Human Resources) **MUST** be notified- magilldl@cobleskill.edu; 518-255-5412
  - Employee must call ARS to report injury 1-888-800-0029
  - If necessary, employee should go to the emergency department, urgent care, or schedule an appointment with their primary care provider.
    - Tell the provider you are seeking treatment under Workers' Compensation
- If an employee seeks medical treatment
  - A doctor's note needs to be provided to supervisor and Donna Magill in Human Resources
    - The note must state
      - Date of treatment
      - Medical restrictions, if any
      - Length of time out of work, if any
- If an employee is taken out of work
  - Employee must follow normal time-off procedures and charge the first 5 days of time off, if applicable.
  - Employee must remain in contact with supervisor and Donna Magill in Human Resources
  - Employee must provide a return to work note stating capacity in which he/she may return, and if any restrictions. If the accommodations can be met the employee may be able to return to work.

SUNY COBLESKILL
EMPLOYEE ACCIDENT REPORT

CAREFULLY FOLLOW DIRECTIONS ON BACK:

1. EMPLOYEE NAME _____ BARGAINING UNIT _____

2. EMPLOYEE'S ADDRESS _____

3. SOCIAL SECURITY NUMBER _____ HOME PHONE NUMBER _____

4. DATE OF BIRTH _____ SEX ☐ Male ☐ Female

5. JOB TITLE _____ DEPARTMENT _____

6. Work Schedule on date of accident _____ PASS DAYS (ex. Sat/Sun) _____ ☐ Full Time ☐ Part Time

7. EMPLOYEE'S WORK LOCATION (Campus Address) _____ CAMPUS PHONE _____

8. HOW LONG EMPLOYED (Date Employee was Hired) _____

9. DATE OF ACCIDENT _____ TIME OF ACCIDENT _____

10. PLACE OF ACCIDENT _____

11. NATURE OF INJURY AND PART(S) OF BODY AFFECTED
HAS THIS BODY PART BEEN INJURED BEFORE? ☐ YES ☐ NO IF YES, WHEN? _____

12. EMPLOYEE REMAINED ON DUTY? ☐ YES ☐ NO **Contact Payroll if out of work, 255-5412**

HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO* IF YES, DATE OF RETURN _____
*Notify Payroll at 255-5412 immediately when employee returns to work

13. EMPLOYEE REQUIRED MEDICAL ATTENTION? ☐ YES ☐ NO* IF YES, WHEN? _____

NAME AND ADDRESS OF DOCTOR _____

NAME AND ADDRESS OF HOSPITAL _____

***If employee later seeks medical attention, contact Payroll at 255-5412 and provide medical documentation**.

14. WHAT WAS EMPLOYEE DOING WHEN INJURED? (BE SPECIFIC; identify tools, equipment or material the employee was using)

_____

15. HOW DID ACCIDENT OR EXPOSURE OCCUR? (Describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened.)

_____

_____

16. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g. the machine employee struck against or which struck him/her; the vapor or poison inhaled or swallowed; chemical that irritated his/her skin. In cases of strains, the thing(s) he/she was lifting, pulling, etc.)

_____

17. SIGNATURE OF EMPLOYEE _____ DATE _____

18. NAMES OF EYEWITNESSES WITH STATEMENT(S) _____

_____

19. SUPERVISOR'S STATEMENT (Include date Supervisor first knew of injury.) _____

_____

20. SUPERVISOR'S SIGNATURE _____ DATE _____

22. SUPERVISOR'S NAME (PRINT) _____

21. CAMPUS ADDRESS _____ CAMPUS PHONE _____

You MUST call 1-888-800-0029 TO REPORT ALL accidents.

Incident #_____ (provided when you call in)

Send **original** to Payroll, Knapp Hall 123 or fax: 255-5657

Send copy to Environmental Health & Safety, Facility Management

Department/Individual retain copy for your records

SUNY COBLESKILL
EMPLOYEE ACCIDENT REPORT

Directions for Completing EAR Part 1: Employee Accident and Investigation Report

Item 1 Employee's name, as it appears on payroll stub and his/her Negotiating Unit (e.g. OSU).

Item 2 Employee's current mailing address.

Item 3 Employee's Social Security number, as it appears on the employee's payroll stub.
Employee's current home telephone number.

Item 4 Employee's date of birth. Indicate employee's sex by checking male or female.

Item 5 Employee's job title and normal work location.

Item 6 Employee's normal shift, i.e., days, evenings or nights (specify hours); the days the employee is normally off duty. Indicate whether the employee works full or part-time.

Item 7 Employee's campus address and phone number.

Item 8 The date the employee was hired.

Item 9 The date and time the employee was injured.

Item 10 The building and floor, unit, or other information to indicate where the accident occurred.

Item 11 Indicate exactly what the injury is and what body part(s) have been affected (e.g., sprain to right ankle, cut to the left forearm, cuts to knees of both legs).

Item 12 This item must be checked after determining whether or not the employee was able to remain at the normal work station. If the employee loses work time as a direct result of this injury or illness, please contact Payroll 255-5412 to indicate the expected duration of the absence. If known, please indicate whether or not the injured employee has returned to work and, if the employee has returned to work, indicate their date of return.

Item 13 Check to determine whether employee required medical attention either immediately after the accident or at some subsequent date. If unknown, check NO. If yes, indicate the name and address of the doctor and/or hospital.

Item 14 Identify the tools, equipment or material that the employee was using and what he/she was actually doing at the time of the injury/illness. Please be specific.

Item 15 Fully describe the events that resulted in the injury or exposure. Specifically explain what happened and how it happened. Particular objects, unsafe conditions, or other factors contributing to the illness or injury should be mentioned.

Item 16 Indicate the machine or tool that caused the injury; the vapor or substance inhaled or swallowed; the chemical that irritated the employee's skin. In cases of strains, the object(s) the employee was lifting, pulling, etc.

Item 17 Employee's signature and date employee completed the form. If the employee is unable or unavailable to sign, please leave blank.

Item 18 Names of eyewitnesses who were present and saw the accident occur, with their description of what happened.

Item 19 The assigned supervisor should describe any condition that may exist or any other relevant information concerning the accident.

Item 20 Supervisor's signature and date the supervisor completes the report.

Item 21 Supervisor's campus work location and telephone number.

Item 22 Supervisor's current home telephone number.

PLEASE CALL WORKERS' COMPENSATION AT 1-888-800-0029 TO REPORT THE INCIDENT.