

EMPLOYEE REPORT OF INJURY

PLEASE RETURN FORM TO: HFM BOCES Business Office
 Attn: Buffy Rousseau
 2755 State Highway 67
 Johnstown, NY 12095
 518-736-4310, x 4688

Our Workers' Utica National Insurance Group
 Comp Carrier: PO Box 5310
 Binghamton, NY 13902

**** Please inform doctor/hospital at the time of treatment that this is an on-the-job injury. ****

YOUR NAME AND ADDRESS:		HOME PHONE:	WORK PHONE:
		DATE OF INJURY:	TIME OF INJURY:
SOCIAL SECURITY NUMBER	DATE OF BIRTH	JOB TITLE	NORMAL WORK HOURS:
ADDRESS WHERE ACCIDENT OCCURRED (please include name of school and location in building):			
WHAT WERE YOU DOING WHEN INJURY OCCURRED?			
HOW DID INJURY OCCUR? (please include detail of any objects that were involved in the injury, i.e. desk, stapler, hammer, ladder, etc.)			
NATURE OF INJURY AND PART OF BODY AFFECTED... BE SPECIFIC (i.e. right hand, left knee, right index finger, strain, cut, bruise, abrasion, etc.)			
LIST ANY WITNESSES (please include names & contact phone numbers):			
WAS MEDICAL CARE PROVIDED (please provide date & time)?		IF SO, NAME OF PHYSICIAN AND/OR HOSPITAL:	
IS THIS RELATED TO A PREVIOUS INJURY? (if yes, please provide details of previous injury)		ARE YOU STILL BEING TREATED FOR INJURY? (if yes, please provide name and address of treating physician)	
DID YOU STOP WORK DUE TO INJURY? (if yes, what date?):		EXPECTED DATE OF RETURN TO WORK?	
EMPLOYEE SIGNATURE:		DATE:	
SUPERVISOR SIGNATURE:		DATE:	

Note: Please report incident to your supervisor as soon as possible after the injury. It is very important that you let us know if you have more than two (2) visits to a doctor or hospital, if you take prescription medicine for this injury (forward the receipt to me), or if you lose any days from work as a result of this injury. Also, after the initial absence for the injury, any other absences may not be considered Workers' Compensation, including follow up doctor appointments.