EMPLOYEE REPORT OF INJURY

PLEASE RETURN FORM TO:

HFM BOCES Business Office
Attn: Jayette Miller
2755 State Highway 67
Johnstown, NY 12095
518-736-4310, x 4688

Our Workers' Comp Carrier:

New York State Insurance Fund
1 Watervliet Avenue
Albany, NY 12206

** **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 need to visit a doctor or hospital or if you lose any days from work as a result of this injury. A network pharmacy must be used for any medications workers may receive for their work-related injury or sickness. Also, after the initial absence for the injury, any other absences may not be considered Workers' Compensation, including follow-up doctors' appointments.