

**ROCHESTER INSTITUTE OF TECHNOLOGY**  
**Workers' Compensation Accident/Injury/Illness Report Form**

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*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 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 am committing a crime and it may result in 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 (First Niagara Business Works) and Third Party Administrator (E.M. Risk Management) 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 Case Manager, Marsha Fitzgerald, First Niagara Business Works at 770-1600/V – select option #1 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

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

***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.***