

# Oswego County Report of Work-Related Injury/Illness (Used for All Injuries/Illnesses (WC, VFF, VAW, 207-a, 207-c))

This is the initial report of the injury/illness, **completed by employer**, and forwarded to the Oswego County Self-Insurance Plan. The information included in this report is very crucial to the completion of the New York State Workers' Compensation Board (WCB) mandated incident reports.

- Date of Injury/Illness:
  - Enter the date the employee has reported that he/she was injured for a specific injury, or the first date of medical treatment for an occupational illness.
- Time of Injury:
  - If a specific injury has occurred, enter the time the specific injury occurred.
- Date of this Report:
  - Enter the date the Incident Report has been completed
- Time Reported:
  - Enter the first time the employee reported the injury/illness to supervisor
- 1) Employer Department
  - Enter the Employer and Department information. For Example, Oswego County Dept. of Personnel, Town of Hannibal Highway Department, McFee Ambulance, etc.
- 2) Address
  - Enter the Employer Mailing Address where future WCB mailing should be received.

## EMPLOYEE INFORMATION

- 3) Employee Name:
  - Enter the injured employee's full legal name.
- 4) Date of Birth:
  - Enter the claimant's date of birth.
- 5) Home Address:
  - Enter the employee's home address, including street number, Town or City, State, and Zip Code.
- 6) Mailing Address (if different from Home Address):
  - If different from the home address, enter the employee's mailing address, including street number, P.O. Box (if applicable). Town or City, State, and Zip Code.
- 7) Social Security Number:
  - Enter the employee's Social Security Number.
- 8) Gender
  - Check the box indicating whether the employee is male or female.
- 9) Work Phone:
  - Enter the employee's contact number at work
- 10) Home/Cell Phone:
  - Enter the employee's contact phone number either home or cell or both, including the area code.
- 11) E-Mail Address
  - Enter the claimant's e-mail address for potential use for correspondence regarding their Workers' Compensation claim

## **INJURY INFORMATION**

- 12) Time of day employee began work on the date of injury:
- Indicate the time of day when the employee began work on the day the injury occurred.
  - If the employee is reporting an illness or occupational disease and an exact date/time cannot be determined, please skip items 12 and 13.
- 13) Where did the injury/illness happen (e.g., 1 East Bridge St, Oswego, at the front door):
- Enter the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness occurred
  - If the employee is reporting an illness or occupational disease and an exact date cannot be determined, please skip items 12 and 13.
- 14) Name of supervisor:
- Enter the name of the employee's direct supervisor. Please include a phone number if possible.
- 15) Did Supervisor see injury happen?
- Check the "YES" or "NO" box indicating whether the supervisor was a witness to the injury/illness.
- 16) When was supervisor first notified:
- Enter the first date and time the supervisor was notified of the injury/illness.
  - If the supervisor was notified by someone other than the employee injured, please provide the name of the person reporting the injury.
- 17) Did anyone else see the injury happen? If yes, give name(s):
- Check the "YES" or "NO" box indicating whether there were any additional witness(es) to the injury/illness.
  - If yes, please provide name, mailing address and contact numbers if possible for future use.
- 18) Description of Incident (e.g., unloading a truck, stocking a shelf, typing report):
- Describe in detail what the employee was doing at the time of the injury/illness. This explains the events leading up to the injury as well as the details of how the injury occurred. For example, unloading boxes from a truck by hand when he tried to catch a box that was falling to the ground.
- 19) Nature of Injury (e.g., cut finger, strained back, twisted knee):
- Indicate fully the nature and extent of the employee's injury/illness, including all body parts injured. Be as specific as possible. For example, strained back, twisted ankle, contusion to upper arm, etc.
- 20) Body Part(s) Involved (e.g. left knee, right shoulder, lower back):
- Please be specific with the body parts injured. For Example, lower back, left arm, right lower leg, groin area, etc.
- 21) Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? If yes, what was it?
- Indicate if some object was involved in the accident OTHER THAN a licensed motor vehicle. Other objects may include a tool (hammer, wrench, etc.), a chemical (acid, etc.), machinery (forklift, drill press, etc.).
- 22) Was the injury the result of the use or operation of a licensed motor vehicle?
- Check the "YES" or "NO" box indicating whether there was a licensed motor vehicle was involved in the accident.
  - If so, please check if the motor vehicle involved was the employee's, employer's, or a third party's and include license plate number (if known). If the employer's vehicle was involved, fill out automobile liability carrier for the vehicle and their address.

## **MEDICAL TREATMENT**

- 23) Was medical treatment sought?
- Check the “YES” or “NO” box indicating whether there it is known whether the claimant sought treatment from a medical provider.
  - If no, skip to #28.
- 24) What was the date of employee’s first medical treatment?
- If the employee treated with a medical provider, enter the date the employee first started treatment for this injury/illness, or state “Unknown” if not known.
- 25) Where did employee receive first medical treatment for this injury/illness?
- Check the location where the initial medical treatment was administered for this injury/illness.
- 26) Who treated employee and where (e.g., Oswego Hospital, Dr. Smith)?
- Indicate whom was responsible for the treatment/care of the employee (Physician, Nurse, EMT, etc.) Include the name of the person and the facility.
- 27) Is employee still being treated for this injury illness?
- Check the box showing if there is knowledge whether the employee continues to receive ongoing medical treatment. If unconfirmed, please check “Unknown”.

## **RETURN TO WORK**

- 28) Did employee lose time from work because of injury/illness?
- Check whether the claimant has lost any time from work because of this injury/illness?
- 29) Did employee stop work because of his/her injury/illness? If yes, on what date?
- Check whether the claimant had stopped working because of this injury/illness?
  - If the employee has stopped working as a result of this injury/illness, indicate the first full day of work the employee stopped working.
- 30) Date employee returned to work?
- If the employee has since returned to work, indicate what date the employee started working again, as well as if the employee has returned to their normal duties or on a limited/restricted duty basis.

## **EMPLOYEE’S WORK INFORMATION (on the date of the injury or illness)**

- 31) Date employee hired:
- Indicate the date the employee was hired by the employer.
- 32) Employee’s job title?
- Enter the employee’s current job title.

## **EMPLOYEE’S PAYROLL INFORMATION (on the date of the injury or illness)**

- 33) Employee’s job was (check one):
- Check whether the claimant was a full-time, part-time, seasonal, volunteer or other employee
- 34) Which days of the week did the employee usually work:
- Check which days of the week the employee usually worked. If the employee did not work a standard work week, please explain.
- 35) Was the employee paid for a full day on the day of the injury/illness:
- Check if the employee was paid for a full day’s work on the day of the injury/illness.

36) `Did the employer continue to pay the employee after the injury/illness:

- Check if the employee continued to receive pay after the injury/illness, such as sick leave or disability pay.
  
- Please have the person completing the incident report to complete the last fields on the Incident report named: “Person Preparing Form:”, “Date:”, “Title:”, “Phone Number:”

**Once the form is completed, please forward to:**

Melissa A. Turner  
Oswego County Self-Insurance Plan  
46 East Bridge Street  
Oswego, NY 13126

Fax: (315) 349-8254  
E-mail: [mturner@oswegocounty.com](mailto:mturner@oswegocounty.com)