

OFFICE USE ONLY

- Incident Only
- Medical Only
- Lost Time

EV _____

**OSWEGO COUNTY SELF-INSURANCE PLAN
REPORT OF WORK-RELATED INJURY/ILLNESS**

Date of Injury/illness: _____

Time of Injury: _____ AM PM

Date of this Report: _____

Time Reported: _____ AM PM

EMPLOYER INFORMATION

1. Employer/Department: _____
(e.g., Oswego County Dept. of Personnel, McFee Ambulance, Town of Hannibal, etc)

2. Address: _____
(Street Address, City, State and Zip)

EMPLOYEE INFORMATION

3. Employee Name: _____

4. Date of Birth: _____

5. Home Address: _____
(Street Address, City, State and Zip)

6. Mailing Address (if different from home address): _____
(Street Address, City, State and Zip)

7. Social Security Number: _____

8. Gender: Male Female

9. Work Phone: _____

10. Home/Cell Phone: _____

11. E-mail Address: _____

INJURY INFORMATION

12. Time of day employee began work on date of injury: _____ AM PM

13. Where did the injury/illness happen (e.g., 1 East Bridge St, Oswego, at the front door): _____

14. Name of supervisor: _____

15. Did Supervisor see injury happen? YES NO

16. When was supervisor first notified: _____

17. Did anyone else see the injury happen? YES NO If yes, give name(s): _____

18. Description of Incident (e.g., unloading a truck, stocking a shelf, typing report): _____

19. Nature of Injury (e.g., cut finger, strained back, twisted knee) : _____

20. Body Part(s) Involved (e.g. left knee, right shoulder, lower back): _____

21. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? YES NO

If yes, what was it? _____

22. Was the injury the result of the use or operation of a licensed motor vehicle? YES NO

If yes, Employee's vehicle Employer's vehicle Other vehicle (License Plate No. if known) _____

MEDICAL TREATMENT

23. Was medical treatment sought? YES NO

24. What was the date of employee's first medical treatment? _____

25. Where did employee receive first medical treatment for this injury/illness?

- On-site (First Aid) Clinic/Hospital/Urgent Care
- Doctors Office Hospital Stay over 24 hours
- ER Unknown

26. Who treated employee and where (e.g., Oswego Hospital, Dr. Smith)? _____

27. Is employee still being treated for this injury illness? Yes No Unknown

RETURN TO WORK

28. Did employee lose time from work because of injury/illness? YES NO

29. Did employee stop work because of his/her injury/illness? Yes No If yes, on what date? _____

30. Date employee returned to work? _____

EMPLOYEE'S WORK INFORMATION (on the date of the injury or illness)

31. Date employee hired: _____ 32. Employee's job title? _____

EMPLOYEE'S PAYROLL INFORMATION (on the date of the injury or illness)

33. Employee's job was (check one): Full Time Part Time Seasonal Volunteer Other

34. Which days of the week did the employee usually work: M T W TH F SA SU

35. Was the employee paid for a full day on the day of the injury/illness: YES NO

36. Did you continue to pay the employee after the injury/illness: YES NO

Person Preparing Form: _____

Date: _____

Title: _____

Phone Number: _____

Please complete and file with Oswego County Self-Insurance for any on-the-job injury/illness. All questions must be answered completely. If you have questions regarding the filing of this form, please contact the Oswego County Self-Insurance Office at (315) 349-8207.

Please submit by mail, fax or electronically:

Oswego County Self-Insurance Plan
46 East Bridge Street
Oswego, NY 13126
Fax: (315) 349-8254
E-mail: mturner@oswegocounty.com