Chautauqua County Self Insurance Plan
ACCIDENT/INJURY REPORT FORM
Type or Print Legible

(The injured worker and supervisor must complete and file this report within 24 hours of the accident. Send the report to Dennis Brooks Gerace Office Building Finance Department, Mayville, N Y 14757, Fax: 716-753-4888 Email: BrooksD@co.chautauqua.ny.us WITHIN 48 hours.

PART A: INJURED WORKER'S STATEMENT OF ACCIDENT/ILLNESS

Municipality and Address:		Department Name:
Employee Name (Last, First, Middle):		SSN:
Home address:		Date of Hire:
Work phone:	Home Phone:	Cell Phone:
Job Title:	Gender: M/F	Number of days worked per week:
Date of Birth:	Employment Status FT/PT:	Emergency Contact name and number:
Date of occurrence:	Time of accident:	Time employee began work:
Date and Time reported to supervisor:	Location of injury occurrence:	

What caused the injury (check all that contributed):

- ☐ Blood/fluid exposure
- ☐ Rubbed or abraded by
- ☐ Struck against object
- ☐ Noise Exposure
- ☐ Toxic Material Exposure
- ☐ Electric Shock
- ☐ Lifting and/or carrying
- ☐ Struck by flying/thrown object
- ☐ Slip, Trip, Fall
- ☐ Motor Vehicle Accident
- ☐ Caught in/under/between object
- ☐ Struck by an object/person
- ☐ Assaulted by client/person
- ☐ Other: _____

Nature of the injury (i.e. laceration, burns, fracture):	Body part(s)injured:	Previous injury to same body part:
If yes, give details:		

Accident Description:

Initial Treatment:

☐ No Medical Treatment ☐ Minor on-site first aid ☐ Minor Treatment with primary care/urgent care/hospital
☐ Emergency Evaluation ☐ Hospitalization greater than 24 hours ☐ Future medical/lost time anticipated

Signature:_____ **Date:**_____

Employee Name: **Date of Injury:**

Part B: SUPERVISOR'S STATEMENT

Injury:		Location:
Did injured worker receive medical treatment:	Date:	Name and address of hospital or physician:
Death Result of Injury: Y/N	Date of Death:	Number of Dependents:

Describe the circumstances causing the accident/injury:

Witnesses (attach statements as appropriate):

Name: _____ Title: _____ Phone #: _____

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What preventative measures could avoid similar occurrences (PPE, Engineered changes, proper training, etc.:

Describe any unsafe practice:	Was Accident Investigated by a Safety Officer or Accident Reconstruction?

Did injured worker lose time from work:

Full Wages Paid for Date of Injury: Y/N	Employer Pd Salary in Lieu of Compensation: Y/N
Has the injured worker returned to work:	If yes, date returned:
Any Physical Restrictions?	If yes, describe:
Supervisor's Name:	**Signature:**
Phone ext:	Date Completed:

Notes: