Employees: Check your Work Location:

❒ Hospital

❒ Hospital Off-site (State employees only)

Specify: ______________________________

❒ LISVH

Campus and Research Foundation employees must complete their own respective alternate report form.

Stony Brook Medicine

EMPLOYEE INJURY/ILLNESS REPORT

Instructions and Distribution on 2nd page

EH&S Use Only:

❒ PESH Non-Recordable

❒ PESH Recordable Case # _______________

❒ LT FDO ___________ RTW ___________

❒ Medical Treatment

❒ Injury Type: _______________________

EMPLOYEE INFORMATION AND INJURY/ILLNESS INFORMATION: To be completed by Employee (or Supervisor, if employee is unable)

Last Name ____________________ First ____________________ MI ___ Date of Birth __________ Gender ❒ M ❒ F

Home Address ______________________________ City ____________________ State _____ Zip _______

Department ______________________________ Job Title ______________________________

Date of Hire ___________ Shift Start Time _______ ❒ AM ❒ PM End Time _______ ❒ AM ❒ PM Pass Days _______________

Employee ID # ____________________ Work Phone ______________ Home Phone ______________ Cell ______________

Date of Incident ___________ Time of Incident _______ ❒ AM ❒ PM Event occurred ❒ before ❒ during ❒ after work shift

Specific Location of Incident (Building/Dept/Floor/Room) ______________________________

What was the employee doing just before the incident occurred? Describe the activity, and the tools, equipment, or materials the employee was using. Be specific. (Example: "Transferring a patient from bed to a chair.")

____

____

What happened? How did the incident occur and what object or substance directly injured the employee? (Example: "Patient became unsteady and employee tried to hold him up.")

____

____

____

What is the injury/illness? List body part affected and nature of the injury/illness. Be more specific than "hurt" or "pain." (Example: "Chemical burn on right hand.")

____

____

ILLNESS CASES ONLY:	❒	Check this box if the employee independently and voluntarily requests that his or her name not be entered on the log. If checked, this incident will be treated as a privacy concern case.

Section Completed by (Print) ____________________ (Signature) ____________________ Date __________

WITNESS INFORMATION: To be completed by Witness(es)

Name ______________________________ Name ______________________________

Statement ______________________________ Statement ______________________________

______________________________ ______________________________

Signature ________________ Work Phone ____________ Signature ________________ Work Phone ____________

SUPERVISOR INFORMATION: To be completed by Supervisor

Supervisor Statement ____

____

Planned Corrective Action (to prevent a reoccurrence) ____

____

Print Name ______________________ Signature ______________________ Date __________

Date/Time Supervisor notified ______________________________ Work Phone __________

MEDICAL INFORMATION: To be completed by Medical Provider

Location where treatment was rendered: ❒ Employee Health & Wellness ❒ Stony Brook ED

❒ Other: Medical Provider/Facility Name ______________________________ Phone __________

Address ______________________________ State _____ Zip _____

Date of visit ___________ Time of visit _______ ❒ AM ❒ PM Body part affected ____________________

Type of treatment given *(check "First Aid only" or "Medical Treatment," and check specific medical treatment information)*:

❒ First Aid only (i.e., non-prescription strength medications, band-aids, eye patches, immobilization devices)

❒ Medical Treatment: ❒ Sutures/Dermabond ❒ Fracture ❒ Prescription strength Rx prescribed/dispensed

Statement of Findings ____

____

Education provided: ❒ Yes ❒ No ❒ Medical referral to ____________________ Employee hospitalized? ❒ Yes ❒ No

❒ Employee can return to work ❒ Employee is unable to return to work for _____ days If employee expired, date __________

Name of Medical Provider ____________________ Signature ____________________ Date __________

Instructions for Hospital or LISVH Employees:

(Note: Research Foundation, Campus and FSA employees must use their respective alternate injury/illness form. For further information contact Campus Human Resources 2-6189, RF Human Resources 2-6163, FSA 4-1473)

This report contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Any employee who files a false report will be subject to the appropriate administrative action including disciplinary action pursuant to the applicable collective bargaining unit.

1. Report your injury or illness to your direct supervisor or their designee.
2. Get medical attention if needed. Report to Employee Health & Wellness or the Emergency Department (ED) during off hours or in a life-threatening emergency, and inform them that your injury is work-related. Employee Health & Wellness or the ED will complete their portion of this report. If you have not received medical attention at this time, this must be noted on the form. If medical attention is sought at a later date, documentation must be provided from your private medical provider to Timekeeping (z=9121).
3. All occupational injuries or illnesses that occur to employees while on duty must be promptly reported by the employee to fulfill legal reporting requirements under the NYS Workers' Compensation Laws and the Public Employee Safety and Health Bureau (PESH).

   Complete this report within 24 hours after a work-related injury or illness.

   Return this completed report to your supervisor or designee for proper distribution.
4. In addition to completing this report, the employee must call the NYS Accident Reporting System (ARS) at 888-800-0029 to report the incident and receive an incident number.
5. If the employee was exposed to a hazardous material or a bloodborne pathogen (BBP) the employee must be evaluated by Employee Health & Wellness or the ED; however, the employee is not required to accept treatment. If the injury involves a BBP they must be evaluated within 2 hours of the injury.
6. Notify your direct supervisor or their designee and Timekeeping if your private medical provider extends the off-duty time beyond the time authorized by Employee Health & Wellness or the ED.
7. If subsequent medical attention is received, documentation must be provided from your private medical provider to Timekeeping. The note from the provider should contain a diagnosis or treated body part, prognosis, and estimated date of return. The note can be faxed with this form.
8. Report any medical equipment incidents to Biomedical Engineering (444-1420).
9. **Keep the original report for your records and provide a copy to your supervisor.**
10. Fax completed report as described below.

Important: Promptly completing all of the above steps for reporting your work related injury/illness will ensure payment of all your compensable medical bills and lost work time. In order for the New York State Insurance Fund to evaluate your case for payment of your Workers' Compensation wage replacement benefits and medical bills they need to have a copy of your injury/illness report from your employer, ARS notification, and a medical report from a physician indicating your disability is due to your job-related injury.

DISTRIBUTION:

HOSPITAL Employees: Fax completed report to 631-706-4230 (internal: "9"-706-4230)

Faxed report will simultaneously be received by Timekeeping, Environmental Health & Safety, Workers' Compensation, and Employee Health & Wellness.

LISVH Employees: Fax completed report to LISVH Human Resources, 631-444-8517