

**SUNY COBLESKILL  
REPORT OF INJURY**

Based on State University of New York form CS-13 C2128-681

Campus 28 _____	Date and Time of Incident: MM DD YYYY Time am / / : pm	Date of Report MM DD YYYY / /	To be completed by Safety Supervisor File ID: Yr. No. Sequence
Did the incident involve personal injury: Yes No	Victim Status: Student Faculty/Staff Student Employee	Patrol Officer CAS Patient Other (Specify) _____	Vendor Visitor
	Nature of Incident : Athletic Academic Job Related Student Activity Other (specify) _____		
Name of Injured Person (PRINT CLEARLY LAST NAME, FIRST, Middle Initial) _____			
Home Address: _____			
City _____ State _____ Zip _____ Telephone _____			
Local Address (if different than home): _____			
City _____ State _____ Zip _____ Telephone _____			
Gender: Female Male	Date of Birth: Mo. Day Year / /	Social Security Number: Last 4 digits only XXX-XX-____	Marital Status: Single Married Separated Divorced Unknown
Employee Information:			
Name of office/department where employee is regularly assigned		Job Title and Grade:	Bargaining Unit
Employment Date: Mo. Day Year / /	Work Schedule On Day Of Injury	Pass Days (ex. Sat/Sun)	Full Time Part Time Student Employee
Name of Supervisor:		Date Supervisor Was Notified : / /	
Did Employee Remain On Duty? A) Yes B) No If no, contact Payroll Office 518-255-5412			
Has Employee Returned To Work? Yes Date of return (mm/dd/yyyy) : ___ / ___ / ___ No Not Applicable Notify Payroll Office immediately, when employee returns to work		Does The Employee Have Restricted Duties? No Yes Explain _____	
*All employee injuries must be reported to the Worker's Compensation Program by calling 1-888-800-0029. Date WC Program notified ( mm/dd/yyyy) ___ / ___ / ___ Incident # _____ provided by WC program Send <b>original</b> of this form to the Payroll Office, Knapp Hall Rm. 123 or fax to 518-255-5657. Send a copy of Environmental Health & Safety Office in Facilities Management Office.			
Injury Information:			
General Location of Occurrence : Residence Hall Dining Hall Student Union Academic Bldg Gym Admin. Bldg Maint. Bldg. Roadway Parking Lot Grounds		Specific Area of Occurrence (Location or Building & Room)	
Sidewalk Athletic Field Other _____			
Part Of Body Injured Abdomen Elbow Hand Lip Teeth Ankle Eye Head Neck Thigh Arm Face Hip Nose Toes Back Finger Knee Shoulder Trunk Chest Foot Leg Spine Wrist		Type of injury: (Select all that apply: Provide details in narrative Abrasion Concussion Puncture Other (Specify) Amputation Cut Swelling Bruise Dislocation Sprain Burn (Heat) Fracture Strain Burn (Chem.) Laceration Tooth (Broken or Knocked Out)	
Other (Specify) _____			
Extent of Injury: Fatal Major Minor	Nature of Injury: Temporary Permanent	Were safeguards provided? Yes No	Were safeguards in use? Yes No
Medical Assistance Rendered: (Check all that apply: Provide details in narrative) First Aid by Staff Health Center Ambulance Hospital Other _____ Medical Assistance Not Required			
Name and Address of Physician Providing Care: _____		Name And Address Of Hospital Providing Care _____	
<b>NARRATIVE</b> ( Give a brief description of who, what, when, where, how, etc. Continue on back if needed)			
List names and addresses of witnesses:			
Report Completed By: (Print Clearly)		Title:	Date:
Supervisor's Signature		Title:	Date:
Safety Officer's Signature		Title:	Date:

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06/2019

**For injuries involving employees provide all information requested.**

Be certain to

- Use employee's name, as it appears on payroll stub.
- Use employee's current mailing address.
- Use employee's current home telephone number.
- Indicate whether or not the employee was able to remain at the normal work station. If the employee loses work time as a direct result of this injury or illness, please contact Payroll (518-255-5412) immediately to indicate the expected duration of the absence. If known, please indicate whether or not the injured employee has returned to work. If the employee has returned to work, indicate the date of return and any restrictions of duty.

The assigned supervisor should add to the narrative section any condition that contributed to the injury exist or any other relevant information concerning the incident. The supervisor's must sign and date the report.

**EMPLOYEES MUST CALL WORKERS' COMPENSATION AT 1-888-800-0029 TO REPORT THE INCIDENT.**

**For all injuries**

- Be as specific as possible when describing the location at which the injury occurred.
- Indicate which body part(s) have been affected (e.g., sprain to right ankle, cut to the left forearm, cuts to knees of both legs) and the type of injury.
- Indicate if medical assistance was provided immediately after the incident or at some subsequent date. If applicable, indicate the name and address of the doctor and/or hospital.
- In the narrative section, fully describe the events that resulted in the injury. Be certain to note any particular objects/tools, vapors/chemicals/substances, environmental conditions, or other factors that contributed to the injury. In cases of strains, include the object(s) the employee was lifting, pulling, pushing, etc.
- Provide names and address (or phone numbers) of witnesses.

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Area for additional narrative & information