SUNY COBLESKILL

REPORT OF ACCIDENT OR INJURY

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

| Campus<br>28____ _____ | Date and Time of Incident:<br>MM DD YYYY Time<br>/ / : | am ○<br>pm ○ | Date of Report<br>MM DD YYYY<br>/ / | To be completed by Safety Supervisor<br>File ID: Yr. No.<br>Sequence |
|---|---|---|---|---|
| Did the incident involve personal injury:<br>○ Yes ○ No | Victim Status: ○ Student ○ Faculty/Staff ○ Patrol Officer ○ CAS ○ Patient ○ Vendor ○ Visitor<br>○ Other (Specify) _____ | | | |
| | Nature of Incident : ○ Athletic ○ Academic ○ Job Related ○ Student Activity ○ Other (specify)_____ | | | |

Name of Injured Person

(PRINTCLEARLY LAST NAME, FIRST, Middle Initial) _____

Home Address:_____

City_____State_____Zip_____ Telephone_____

Local Address (if different than home):_____

City_____State_____Zip_____ Telephone_____

| Gender:<br>○ Female<br>○ Male | Date of Birth:<br>Mo. Day Year<br>/ / | Social Security Number:<br>Last 4 digits only<br>XXX-XX- _ _ _ _ | Marital Status:<br>○ Single ○ Separated<br>○ Married ○ Divorced ○ Unknown |
|---|---|---|---|

Employee Information:

| Name of office/department where employee is regularly assigned | Job Title and Grade: | Bargaining Unit |
|---|---|---|

| Employment Date: Mo. Day Year<br>/ / | Work Schedule On Day Of Injury | Pass Days (ex. Sat/Sun) | ○ Full Time ○ Part Time<br>○ Student Employee |
|---|---|---|---|

| Name of Supervisor: | Date Supervisor Was Notified : / / |
|---|---|

Did Employee Remain On Duty? ○ Yes ○ No If no, contact Payroll Office 518-255-5412

| Has Employee Returned To Work?<br>○ Yes Date of return (mm/dd/yyyy) : __ / __ / ____ ○ No ○ Not Applicable<br>Notify Payroll Office immediately, when employee returns to work | Does The Employee Have Restricted Duties?<br>○ No<br>○ 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 **original** 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 :<br>○ Residence Hall ○ Dining Hall ○ Student Union ○ Academic Bldg<br>○ Gym ○ Admin. Bldg ○ Maint. Bldg. ○ Roadway ○ Parking Lot ○ Grounds<br>○ Sidewalk ○ Athletic Field ○ Other_____ | Specific Area of Occurrence (Location or Building & Room) |
|---|---|

| Part Of Body Injured **Left Side or Right Side**<br>☐ Abdomen ☐ Elbow ☐ Hand ☐ Lip ☐ Teeth ☐ Other<br>☐ Ankle ☐ Eye ☐ Head ☐ Neck ☐ Thigh (Specify)<br>☐ Arm ☐ Face ☐ Hip ☐ Nose ☐ Toes _____<br>☐ Back ☐ Finger ☐ Knee ☐ Shoulder ☐ Trunk<br>☐ Chest ☐ Foot ☐ Leg ☐ Spine ☐ Wrist | Type of injury: (Select all that apply: Provide details in narrative<br>☐ Abrasion ☐ Concussion ☐ Puncture ☐ Other (Specify)<br>☐ Amputation ☐ Cut ☐ Swelling _____<br>☐ Bruise ☐ Dislocation ☐ Sprain<br>☐ Burn (Heat) ☐ Fracture ☐ Strain<br>☐ Burn (Chem.) ☐ Laceration ☐ Tooth (Broken or Knocked Out) |
|---|---|

| Extent of Injury:<br>○ Fatal ○ Major ○ Minor | Nature of Injury:<br>○ Temporary ○ Permanent | Were safeguards provided?<br>○ Yes ○ No | Were safeguards in use?<br>○ 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:<br>_____ | Name And Address Of Hospital Providing Care<br>_____ |
|---|---|

**NARRATIVE** ( 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: |

SUNY COBLESKILL
REPORT OF ACCIDENT OR INJURY
(OTHER THAN A MOTOR VEHICLE ACCIDENT)
Based on State University of New York form CS-13 C2128-681

04/2019

**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.

Area for additional narrative & information