Eastern Suffolk BOCES

Educational Services That Transform Lives

Employee Injury/ Incident Report

Board of Cooperative Educational Services
First Supervisory District of Suffolk County
201 Sunrise Highway
Patchogue, NY 11772

PAGE 1 MUST BE COMPLETED, SIGNED BY EMPLOYEE AND SUPERVISOR, AND FORWARDED TO RISK AND ASSET MANAGEMENT OFFICE WITHIN 24 HOURS OF INCIDENT. PAGE 2 MUST THEN BE FORWARDED TO EMPLOYEE'S SUPERVISOR FOR COMPLETION.

SECTION 1

INJURED EMPLOYEE

Last Name ______ First Name ______ Home Telephone No. ______ Cell Telephone No. ______

Home Street Address ______ City ______ Zip ______

☐ Male ☐ Female

/ / Date of Birth

/ / Date of Hire

Job Title ______ Division ______

SECTION 2A

DESCRIPTION OF INCIDENT

/ /20 Date of Incident ______ Day of Week ______ ☐ AM ☐ PM Time of Incident ______

Location of Incident (Name of Building, Address, Room No., Etc. - **BE SPECIFIC**)

Description of Incident (State what you were doing at the time of the incident and what occurred.)

EXAMPLE: I was walking down the hallway and slipped on the floor.

Witnesses

SECTION 2B

Student Related ☐ Yes ☐ No Was student injured? ☐ Yes ☐ No If "Yes" complete Student Accident Report.

Type of Surface (Carpet, Dirt, Tile, Etc.) ______ Safety Devices in Use (Gloves, Safety Glasses, Etc.) ______

SECTION 3

NATURE OF INJURY

State the nature of the incident, what part(s) of the body were affected, and indicate right or left side (such as injury to the right ear, left elbow, thumb on right hand, resulting in bruises, swelling, etc.)

Was immediate medical care provided? ☐ Yes ☐ No If "Yes" when?

Immediate Medical Provider (Doctor, Ambulance No., Police Badge No., or Vehicle No., Etc.) (Optional)

Name and Address of Hospital (If Applicable)

Was work time lost beyond day of incident? ☐ Yes ☐ No

NY FRAUD STATUTE

The Insurance Law of the State of New York provides that any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

SECTION 4

Signature of Employee ______ ESBOCES Telephone No. ______

Title of Employee ______ / /20 Date of Report

Signature of Supervisor (Acknowledges Receipt of Form) ______ / /20 Date Supervisor was Advised of Injury

Signature of Building Administrator ______ Building Administrator's Telephone No. ______

Name of Employee ______________________ **Date of Incident** ____/____/____

THE FOLLOWING SECTION IS TO BE COMPLETED BY SUPERVISOR WITHIN FIVE (5) BUSINESS DAYS OF RECEIPT OF *EMPLOYEE INJURY/INCIDENT REPORT* AND FORWARDED TO RISK AND ASSET MANAGEMENT OFFICE – HINES ADMINISTRATION CENTER. DESCRIBE IN DETAIL THE TASK THE EMPLOYEE WAS COMPLETING AT THE TIME OF INJURY (INCLUDE VEHICLE, EQUIPMENT, OR TOOLS USED).

SECTION 5 – EMPLOYEE INJURY/INCIDENT REPORT ACCIDENT ANALYSIS

Interview witnesses or co-workers for additional insights, if necessary. ☐ Additional sheet attached for supplementary information/comments

Was this the employee's regular work assignment? ☐ Yes ☐ No

*** * * Any O checked in this section <u>requires</u> a comment. * * ***

Contributing Factors	Yes	No	N/A	Comments	Corrective Action
Environment					
1.1 Did the work area design contribute to the injury?	O	☐	☐		☐
1.2 Was the area cluttered?	O	☐	☐		
1.3 Did the employee have to be in this area to complete the job?	☐	O	☐		
1.4 Were other conditions (e.g., set floor, extreme temperatures, etc.) a contributing factor?	O	☐	☐		
1.4 Were there other environmental issues affecting safety? If so, what?	O	☐	☐		
Equipment/Tools					
2.1 Was the correct equipment being used?	☐	O	☐		☐
2.2 Was the correct equipment readily available?	☐	O	☐		
2.3 Did any defects or change in equipment/material contribute to hazardous conditions? If so, what?	O	☐	☐		
2.4 Is regular maintenance done on affected machinery/equipment?	☐	O	☐		
2.5 Was the employee using proper PPE (shoes, apron, goggles)?	☐	O	☐		
Method					
3.1 Was employee performing according to accepted work method?	☐	O	☐		☐
3.2 Was there a better method to perform the task? If so, what?	O	☐	☐		
3.3 Did employee comply with directives in student's IEP?	☐	O	☐		
3.4 Were CPI methods necessary?	O	☐	☐		
3.5 Were proper CPI methods used?	☐	O	☐		
Employee					
4.1 Was employee using all required safety equipment for task?	☐	O	☐		☐
4.2 Was employee trained on necessary equipment for the task?	☐	O	☐		
4.3 Was employee authorized to operate the equipment?	☐	O	☐		
4.4 Were required safety procedures being followed? If not, why?	☐	O	☐		
Management					
5.1 Were the behaviors that caused the injury/illness observed before?	O	☐	☐		☐
5.2 If so, what was done?					
5.3 Does management require specific safe work practices related to this task? If so, explain what was expected.	O	☐	☐		
5.4 Have safety related changes been made/suggested for this task?	O	☐	☐		

To correct unsafe acts: ☐ Review/change procedures ☐ Train/retrain injured employee ☐ Instruct all employees ☐ Other (Explain) ______________________

To correct unsafe conditions: ☐ Eliminate the hazard ☐ Request repairs ☐ Initiate ergonomic review ☐ Conduct periodic inspections

Specific Corrective Actions	Assigned To	Date
1. ______________________	______________	______________
2. ______________________	______________	______________
3. ______________________	______________	______________
4. ______________________	______________	______________

______________________ Signature of Supervisor

____/____/20____ Date

SOME POSSIBLE REMEDIAL ACTIONS FOR CLASSROOM-RELATED INJURIES

Cause of Injury	Possible Remedial Actions
Student Aggression	• Establish administrative protocol to ensure that all employees know their individual student plans before interaction; review periodically and obtain sign-off • Define and train employees in, and reinforce use of, basic best practices, such as maintaining adequate distance, keeping hair short or restrained, watching for distress clues, and requesting assistance before crisis develops
Slips/Falls – Wet Floors	• Establish guidelines for janitorial staff to provide sop mats at all entrances prior to facility opening during inclement weather • Establish guidelines for janitorial staff to patrol and clean entranceways more often during inclement weather • Establish a “Spill” code for the public announcement system to easily alert janitorial staff to spills and puddles • Establish a protocol for all employees to post a watch and/or place cones at any spill/puddle to guide others around until it can be cleaned
Slips/Trips/Falls – Housekeeping	• Train employees in, and reinforce use of, a plan to ensure a clear path before assisting to move/guide a student • Train/require employees to pick up after themselves and students to keep walkways clear
Strains/Sprains from Assisting Students	• Define and train employees in, and reinforce use of, proper techniques for assisting students when standing, sitting, toileting, walking, etc. • Provide adequate lifts, train employees in, and reinforce, proper use of lifts and mechanical aids as may be needed for students requiring high levels of assistance • Train/require employees to assess needs and obtain assistance from other employees when situation exceeds reasonable physical capabilities for one person
General Strains/Sprains	• Define and train employees in, and reinforce, use of proper techniques for lifting, pushing, and pulling • Train employees in, and reinforce, proper use of machinery utilized by custodial staff • Train/require employees to assess needs and obtain assistance from other employees when situation exceeds reasonable physical capabilities for one person

State of New York
WORKERS' COMPENSATION BOARD

Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider

Injured Employee's Name	Injured Employee's Social Security No.	Date of Accident
Employer's Name and Address		

To the Injured Employee:
For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Workers' Compensation Board authorized and who is accepting workers' compensation patients.

While you may choose to utilize a network or provider which is recommended by your employer or its workers' compensation insurance carrier or to permit your employer to select a provider on your behalf, you may, at any time, change your health care provider without jeopardizing your workers' compensation claim for benefits.

Signature of Injured Employee	Date	Signature of Witness	Date

Please note: It is not necessary for you to sign this consent form if your employer is (i) participating in a certified preferred provider organization (PPO) under Article 10-A of the Workers' Compensation Law, or (ii) participating in the alternative dispute resolution (ADR) pilot program under section 25(2-c) of the Workers' Compensation Law. In accordance with these statutory programs, except in emergency situations, you must obtain at least initial treatment for any workers' compensation injury or illness from the certified network(s) or providers designated by your employer.

To the Employer:
The employer shall provide the above-named injured employee with a copy of this signed form and shall maintain the original form in the employer's records where it may be inspected by the Workers' Compensation Board at any time. This form shall not be submitted to the Workers' Compensation Board nor shall it be executed prior to the occurrence of this employee's work-related injury or illness.

The Workers' Compensation Board employs and serves people with disabilities without discrimination.