

**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.**

<b>SECTION 1</b>	Last Name _____	First Name _____	Home Telephone No. _____	Cell Telephone No. _____
<b>INJURED EMPLOYEE</b>	Home Street Address _____		City _____	Zip _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	Date of Hire _____	
	Job Title _____		Division _____	

<b>SECTION 2</b>	Date of Incident _____ / ____ /20	Day of Week _____	Time of Incident <input type="checkbox"/> AM <input type="checkbox"/> PM
<b>DESCRIPTION OF INCIDENT</b>	Location of Incident (Name of Building, Address, Room No., Etc. - <b>BE SPECIFIC</b> ) _____		
	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 _____			
Type of Surface (Carpet, Dirt, Tile, Etc.) _____		Safety Devices in Use (Gloves, Safety Glasses, Etc.) _____	
Student Related <input type="checkbox"/> Yes <input type="checkbox"/> No		Was student injured? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" complete Student Accident Report.	

<b>SECTION 3</b>	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.) _____
<b>NATURE OF INJURY</b>	_____
	_____
	_____
Was immediate medical care provided? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>NY FRAUD STATUTE</b>	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.

<b>SECTION 4</b>	Signature of Employee _____	ESBOCES Telephone No. _____
	Title of Employee _____	Date of Report _____
	Signature of Supervisor (Acknowledges Receipt of Form) _____	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 requires a comment. \* \* \***

**Environment**

Contributing Factors	Yes	No	N/A	Comments	Corrective Action
1.1 Did the work area design contribute to the injury?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		
1.2 Was the area cluttered?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		
1.3 Did the employee have to be in this area to complete the job?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		<input type="checkbox"/>
1.4 Were other conditions (e.g., set floor, extreme temperatures, etc.) a contributing factor?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		
1.4 Were there other environmental issues affecting safety? If so, what?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		

**Equipment/Tools**

2.1 Was the correct equipment being used?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
2.2 Was the correct equipment readily available?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
2.3 Did any defects or change in equipment/material contribute to hazardous conditions? If so, what?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="checkbox"/>
2.4 Is regular maintenance done on affected machinery/equipment?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
2.5 Was the employee using proper PPE (shoes, apron, goggles)?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		

**Method**

3.1 Was employee performing according to accepted work method?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
3.2 Was there a better method to perform the task? If so, what?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="checkbox"/>
3.3 Did employee comply with directives in student's IEP?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
3.4 Were CPI methods necessary?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		
3.5 Were proper CPI methods used?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		

**Employee**

4.1 Was employee using all required safety equipment for task?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
4.2 Was employee trained on necessary equipment for the task?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		<input type="checkbox"/>
4.3 Was employee authorized to operate the equipment?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
4.4 Were required safety procedures being followed? If not, why?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		

**Management**

5.1 Were the behaviors that caused the injury/illness observed before?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		
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.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="checkbox"/>
5.4 Have safety related changes been made/suggested for this task?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		

**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**

<b>Cause of Injury</b>	<b>Possible Remedial Actions</b>
Student Aggression	<ul style="list-style-type: none"> <li>• Establish administrative protocol to ensure that all employees know their individual student plans before interaction; review periodically and obtain sign-off</li> <li>• 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</li> </ul>
Slips/Falls – Wet Floors	<ul style="list-style-type: none"> <li>• Establish guidelines for janitorial staff to provide sop mats at all entrances prior to facility opening during inclement weather</li> <li>• Establish guidelines for janitorial staff to patrol and clean entranceways more often during inclement weather</li> <li>• Establish a “Spill” code for the public announcement system to easily alert janitorial staff to spills and puddles</li> <li>• 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</li> </ul>
Slips/Trips/Falls – Housekeeping	<ul style="list-style-type: none"> <li>• Train employees in, and reinforce use of, a plan to ensure a clear path before assisting to move/guide a student</li> <li>• Train/require employees to pick up after themselves and students to keep walkways clear</li> </ul>
Strains/Sprains from Assisting Students	<ul style="list-style-type: none"> <li>• Define and train employees in, and reinforce use of, proper techniques for assisting students when standing, sitting, toileting, walking, etc.</li> <li>• 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</li> <li>• Train/require employees to assess needs and obtain assistance from other employees when situation exceeds reasonable physical capabilities for one person</li> </ul>
General Strains/Sprains	<ul style="list-style-type: none"> <li>• Define and train employees in, and reinforce, use of proper techniques for lifting, pushing, and pulling</li> <li>• Train employees in, and reinforce, proper use of machinery utilized by custodial staff</li> <li>• Train/require employees to assess needs and obtain assistance from other employees when situation exceeds reasonable physical capabilities for one person</li> </ul>

**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.