SUNY Oswego Employee Work Related Injury & Illness Report

Supervisors must complete this report when an employee sustains a work-related injury or illness. Please ***return the completed form to Human Resources*** *as soon as possible.*

Employee Name	Employee ID Number	DOB		Home Phone
Home Street Address				
City, State, Zip		Occupation/Job Title		
Department Name		Supervisor Name		Supervisor Phone
Date of Incident	Time of Incident	Time Began Work	Time Stopped Work	Finished Shift?
Location of Incident (Building Name, Room Number, City, State, Zip)				On SUNY Oswego Property?
How did the incident occur? Describe the activity and any tools, equipment, or material used.				
List the body part(s) injured and type of injury:				
How do you think this type of incident can be prevented?				
Witnesses? __Yes __No	If Yes, Witness #1 (Name & Phone)	Witness #2 (Name & Phone)		
Is this a new injury? __Yes __No	If No, please describe the original injury:			Date of Original Injury
Did you receive treatment? __Yes __No If Yes then notify the NYS Accident Reporting System (NYS ARS) for the employee if they are not able to do so themselves the NYS ARS toll free number is 1-888-800-0029 . __Treatment will be provided or sought __ declined treatment at the time __Reporting only(no treatment needed- proceed to signature section)				
If you received treatment, who provided it?				
Provider Name, Address, and Phone (if name not above)				
Did the employee return to work the same day or following day (excluding pass day)? __Yes __No		Did the employee provide documentation to return to work? __Yes __No		
Supervisor's Signature:		Date:		
Employee's Signature:		Date:		

Date Completed Report Received by Human Resources _____