NewYork-Presbyterian
The University Hospital of Columbia and Cornell

EMPLOYEE ACCIDENT / INCIDENT REPORT

INSTRUCTIONS

PLEASE USE A BLACK PEN, PRINT CLEARLY AND PRESS HARD.

EMPLOYEE:

- Report ALL work related accidents/incidents to your supervisor immediately.
- Fill out and sign the EMPLOYEE section of this form as soon as possible after the event. Fill in all the boxes.
- Have your supervisor sign the report. Explain what happened and why it happened, if possible.
- Bring this report form to Occupational Health Service (OHS) as soon as possible. If you need medical care and OHS is closed, take this form to the Emergency Department and bring the form to OHS on the next business day.
- Return the remaining copies of the form to your supervisor *after* treatment in OHS.

IF YOU ARE PLACED OFF DUTY:

- Notify OHS immediately, as a delay may affect your workers' compensation benefits.
- You must report to OHS ***before*** you can return to duty.
- No employee will be paid workers' compensation benefits without a completed Employee Accident/Incident Report ***and*** a medical report from the practitioner providing treatment.

SUPERVISOR:

- Review the EMPLOYEE section of the form. Make sure it is filled out completely and accurately.
- Fill out and sign the SUPERVISOR section of the form.
- Send employee to OHS for evaluation. When OHS is closed, send employee to the Emergency Department (ED) ***and*** call Ext. 6-7000 (212/305-7000), the 24-hour Hot Line, to report the accident. Accidents must be reported immediately! Provide information indicated below*
- Fill out the SUPERVISOR'S FOLLOW-UP section after employee returns from OHS or ED with the form. Follow guidelines on back of this page (Responsibilities Following an Accident).
- Keep the Department copy.
- Send the Safety copy to the Safety Department within 5 days of the accident/incident.

SERVICE	EXTENSION	TELEPHONE	LOCATION
24-Hour Hot Line	6-7000	(212) 305-7000	*Leave employee's name, department, phone number, date & type of accident.
Occupational Health Service (OHS)	6-7590	(212) 305-7590	Harkness Pavilion, First Floor, South **Monday - Friday 8:30 AM - 4:30 PM**
Emergency Department (at CPC)	6-4979	(212) 305-4979	Vanderbilt Clinic - First Floor
Emergency Department (at TAP)	4-4245	(212) 932-4245	The Allen Pavilion, 5141 Broadway
Urgi Care Center	6-3061	(212) 305-3061	Audubon ACNC, 21 Audubon Avenue
Safety Department	6-2737	(212) 305-2737	Eye Institute, Basement, Room B-37

RESPONSIBILITIES FOLLOWING AN ACCIDENT / INCIDENT

EMPLOYEE	SUPERVISOR	DEPARTMENT HEAD

• **Report Accident/ Incident to Supervisor immediately**
 	
• Complete Employee's section of Employee Accident/Incident Report Form. ***Fill in all boxes.***
 	
• If injured or ill, obtain medical treatment at Occupational Health Service (OHS) or Emergency Department.
 	
• Bring Accident/ Incident Report form back to supervisor, after OHS copy has been removed at treating location.
 	
• Assist supervisor in accident investigation.
	• Be sure employee has received medical attention, if injured.
	• Review employee information for completeness and accuracy, e.g., correct name of department, work location, etc. Answer all questions completely. Add another sheet, if necessary for investigation and follow-up.
	
	• **Investigate accident promptly and thoroughly:**
	• Interview employee:
	  • Proceed step by step in sequence of events. What happened first, etc.
	  • At each step, determine all factors which may have contributed to the accident.
	• Inspect scene of accident, where appropriate.
	• Interview witnesses, where appropriate.
	• Come to a conclusion: **What** caused the accident? **How** did it happen? **Why** did it happen?
	
	• **Determine corrective measures** which would prevent a similar accident, e.g., training, maintenance, different equipment, job redesign, etc.
	
	• **DO IT.** Implement the corrective measures. Refer issues not within your authority to your manager or department head.
	
	• If employee lost time from work:
	  • Mark his/her time card as instructed by OHS.
	  • Follow instructions on Instruction page to report when employee goes off-duty and when he/she returns to work. Notify OHS if employee is placed off-duty by other medical provider.
	
	• The Safety Department is available to assist in accident investigations.
		• **Review and sign every Employee Accident/ Incident Report generated within the department.** Before signing:
		
		• Assure that all questions have been answered in a thorough and professional manner.
		
		• Evaluate the conclusions: will corrective measures indicated be effective in preventing recurrence?
		
		• Follow-up to be sure corrective action has been implemented. Assure implementation throughout the department, as applicable.
		
		• Where corrective measures are not within the authority of subordinates, take the corrective action necessary to achieve their full implementation.
		
		• Disposition of completed form:
		
		• Send to Safety Department within 5 days of accident.
		
		• Maintain Department Copy in department's Accident/Incident File.
		
		• The results of a department's accident investigations should be reviewed periodically (e.g., quarterly) to determine effectiveness of corrective measures and assure they are still in effect. This includes observations of employees performing their tasks, to assure they are performing them safely.

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EMPLOYEE ACCIDENT / INCIDENT REPORT

EMPLOYEE

1. DATE OF ACCIDENT	2. TIME OF ACCIDENT: ☐ AM ☐ PM	3. DATE OF REPORT	4. SHIFT: ☐ DAY ☐ EVE. ☐ NIGHT	5. # DAYS WORKED/WK	6. HOURS/DAY	7. ☐ FULL TIME ☐ PART TIME ☐ OTHER:

8. EMPLOYEE NAME (FIRST, MI, LAST)	9. HOME PHONE ( )	10. WORK PHONE	11. SOC. SEC. NO.

12. EMPLOYEE HOME ADDRESS (NUMBER, STREET, APT #, CITY, ZIP CODE)	MRN	13. SEX: ☐ M ☐ F	14. DATE OF BIRTH

15. DEPARTMENT	16. WORK LOCATION	17. JOB TITLE	18. AFFILIATION: ☐ 1199 ☐ NYSNA ☐ NON-UNION ☐ OTHER:	19. DATE OF HIRE

20. EXACT LOCATION WHERE ACCIDENT OCCURRED (BUILDING, FLOOR, ROOM #)	21. NATURE OF INJURY OR ILLNESS AND PART OF BODY AFFECTED	22. ACCIDENT OCCURRED ON PREMISES? ☐ YES ☐ NO

23. DESCRIBE IN FULL DETAIL HOW ACCIDENT OCCURRED: WHAT HAPPENED, WHAT WERE YOU DOING WHEN INJURED. INCLUDE OBJECTS, SUBSTANCES AND EQUIPMENT INVOLVED.

24. WERE THERE ANY WITNESSES ☐ NO ☐ YES, LIST FULL NAME, DEPARTMENT AND PHONE NUMBER.
(1) (2)

25. AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize any licensed physician, medical practitioner, nurse, pharmacist, hospital, clinic, or other medically-related facility, insurance or reinsurance company, consumer reporting agency, employer or former employer or others who have any information as to the diagnosis, treatment or prognosis of any physical or mental condition of mine, including any alcohol or drug abuse information and any information regarding my occupation or salary, to give any and all such information to _____, its employees, agents, re-insurer, and legal representatives to which I may submit a claim. I agree that a photographic copy of this authorization shall be as valid as the original. I understand that the information obtained by this authorization will be used by _____ to determine eligibility for insurance benefits. Any information obtained will not be released to any person or organization except to other persons or organizations performing a business or legal service in connection with my claim or as may be otherwise permitted or required by law.

26. EMPLOYEE PRINT NAME	EMPLOYEE SIGNATURE	DATE:

SUPERVISOR

27. SUPERVISOR NAME (PRINT)	28. WORK EXT./BEEPER	29. DEPARTMENT

30. SUPERVISOR SIGNATURE	31. DATE	32. COST CENTER

MEDICAL

33. DATE OF TREATMENT	34. TIME: ☐ AM ☐ PM	35. MEDICAL CARE PROVIDED AT: ☐ OHS ☐ ED ☐ OTHER (EXPLAIN):

36. NATURE OF TREATMENT: ☐ NONE ☐ FIRST AID ONLY ☐ MEDICAL TREATMENT (EXPLAIN):

37. DISPOSITION:
☐ RETURN TO REGULAR DUTIES, DATE _____
☐ UNABLE TO RETURN TO WORK AT LEAST _____ WORK DAYS BEYOND DAY OF ACCIDENT
☐ RETURN TO RESTRICTED DUTIES (EXPLAIN):

38. FOLLOW-UP: ☐ NOT REQUIRED ☐ RETURN TO OHS ON (DATE):
☐ REFERRED TO: _____ (DATE):

39. DIAGNOSIS AND PART OF BODY AFFECTED:

40. NAME OF HEALTH CARE PROVIDER (PRINT)	SIGNATURE/CODE	DATE

SUPERVISOR FOLLOW-UP

41. DESCRIBE RESULTS OF INVESTIGATION AND CORRECTIVE ACTION TAKEN TO PREVENT FUTURE OCCURRENCES IN DEPARTMENT. GIVE DATES:

42. SUPERVISOR NAME (PRINT)	SIGNATURE	DATE	WORK EXT.

43. DEPARTMENT HEAD (PRINT)	SIGNATURE	DATE	WORK EXT.