WORKERS' COMPENSATION INJURY REPORTING WORKSHEET
HARTWICK COLLEGE

DO NOT DELAY IN COMPLETING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.

ACCOUNT / ACCIDENT INFORMATION

REPORTING STATE
NEW YORK

SUBSIDIARY'S NAME
HARTWICK COLLEGE

SUBSIDIARY'S ADDRESS (STREET, CITY, STATE & ZIP)
ONE HARTWICK DRIVE, ONEONTA, NY 13820

SUBSIDIARY'S MAILING ADDRESS (STREET, CITY, STATE & ZIP)
☐ SAME

DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS?
☐ YES ☐ NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED

PARENT COMPANY / INSURED'S NAME
HARTWICK COLLEGE

LOCATION CODE

POLICY SYMBOL AND NUMBER

NATURE OF BUSINESS:
HIGHER EDUCATION

DATE OF INJURY

TIME OF INJURY

ACCIDENT DESCRIPTION

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:

EMPLOYEE'S NAME (FIRST, MI, LAST)

GENDER
☐ MALE ☐ FEMALE

DATE OF BIRTH

EMPLOYEE'S MAILING ADDRESS

EMPLOYEE'S HOME PHONE NUMBER
( )

EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE
☐ FULL-TIME ☐ PART-TIME ☐ OTHER____________________

INJURED WORKER TYPE

REGULAR OCCUPATION

OCCUPATION WHEN INJURED

EMPLOYEE'S WORK SCHEDULE
REGULAR WORK HOURS HOURS/DAY DAYS/WEEK

EMPLOYEE'S WAGE INFORMATION:
$ ___________ / HOUR OR $ ___________/ ANNUAL OR $ ___________ / WEEKLY OVERTIME: $ ___________ ADDITIONAL BENEFITS: $ ___________.

DATE OF HIRE OR LENGTH OF EMPLOYMENT

SUPERVISOR'S NAME:

SUPERVISOR'S PHONE NUMBER:
( )

BEST HOURS TO CONTACT

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?

DID EMPLOYEE LOSE ANY TIME FROM WORK?
☐ YES ☐ NO

IS THE EMPLOYEE BACK AT WORK?
☐ YES ☐ NO IF YES, DATE RETURNED TO WORK?

RETURN TO WORK STATUS
☐ LIGHT ☐ MODIFIED ☐ REGULAR

DATE EMPLOYEE LAST WORKED

WAS INJURY FATAL? IF YES, DATE OF DEATH
☐ YES ☐ NO

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)

EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED

DO YOU QUESTION THE VALIDITY OF THE CLAIM?
☐ YES ☐ NO

WITNESS INFORMATION/OTHERS INVOLVED

NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER

CONTINUED ON REVERSE SIDE

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INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)

☐ YES ☐ NO

TREATMENT ("X" ALL THAT APPLY

☐ FIRST AID —	TREATMENT AND DATE OF 1ST TREATMENT
☐ HOSPITAL/ CLINIC —	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1ST TREATMENT, LENGTH OF STAY, AMBULANCE USED? WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT`? ☐ YES ☐ NO
☐ PHYSICIAN —	

ADDITIONAL COMMENTS & INFORMATION

Employee Signature Date