HR/1/08 **SUNY POTSDAM Accident/Injury Report (other than a motor vehicle accident) Agency Code 28250**

HR Received Date

Please check one: State Employee ☐ CSEA ☐ PEF ☐ UUP ☐ M/C ☐ Univ. Police
(State Employees *must* also call 1-888-800-0029 to report this incident)
☐ RF Employee ☐ Student Employee ☐ PACES Employee ☐ Volunteer
☐ Student ☐ Visitor

Full Name:_____

University Police Case #:

_____

Received On:

_____

Health & Safety Received Date:

_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone: (_____)_____ Date of Birth:_____ (Circle One) ☐ MALE ☐ FEMALE

Date of Accident/Injury/Illness:_____ **Time of Event**:_____AM/PM **Time Employee Began Work:**_____AM/PM

Regular Shift:_____ ☐ Full-Time ☐ Part-Time **Pass Days**: _____ **Title**:_____

Date of Hire:_____ **Department**:_____ **Supervisor**:_____

PLEASE CIRCLE YOUR ANSWERS TO THE FOLLOWING:

Were you treated in an emergency room? ☐ YES or ☐ NO
Were you hospitalized overnight? ☐ YES or ☐ NO
Did you remain on duty? ☐ YES or ☐ NO
Have you returned to work? ☐ YES or ☐ NO
If yes, date you returned to work:_____
Do you/will you have restricted duties? ☐ YES or ☐ NO
Were safeguards provided? ☐ YES or ☐ NO
Were safeguards in use? ☐ YES or ☐ NO
Were there any witnesses? ☐ YES or ☐ NO (If yes, please list below)

_____

Specific location where incident occurred: (include building and room #)

_____

If physical injury, part of body injured: (circle one only; most serious) ABDOMEN ANKLE ARM BACK CHEST ELBOW EYE FACE FINGER FOOT HAND HEAD HIP KNEE LEG LIP NECK NOSE SHOULDER SPINE TEETH THIGH TOES TRUNK WRIST OTHER(specify)_____

_____

Specify: ☐ RIGHT or ☐ LEFT

If treatment was given away from the worksite, where was it given? (also, please forward all medical documents to HR)

Facility:_____

Address:_____

City_____ State_____ Zip_____

Name of physician or other health care professional:

_____ Phone #:_____

Date Medical Treatment was given:_____

What was the employee doing just before the incident occurred? (Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer.")

What happened? (Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement.")

What was the injury or illness? (Tell us the part of the body (right or left) that was affected and how it was affected; be more specific than "hurt", "pain", or "sore." *Examples:* "strained back"; "chemical burn, right hand."

What object or substance directly harmed the employee? (*Examples:* "concrete floor"; "radial arm saw"; "chlorine.")

If the employee died, when did death occur?_____
Date of Death

ILLNESS CASES ONLY

☐ Check this box if the employee independently and voluntarily requests that his or her name not be entered on the SH900 log. If checked, treat as a privacy concern case.

HR Use Only: Case Number from the SH900 Log:

Report Completed By:_____ Title:_____ Date:_____

Employee Signature:_____ Campus Phone:_____ Date:_____

Supervisor Signature:_____ Campus Phone:_____ Date:_____
(Acknowledgement of notification)

ORIGINAL – Human Resources **YELLOW –** University Police **PINK –** Health/Safety Officer