SKIDMORE COLLEGE

Accident Reporting Form for Employees and Student Employees

This form should be faxed to Human Resources at ext. 5805 **within 24 hours of accident** by the Supervisor

Form Must Be Completed By the Supervisor While Interviewing Employee

Complete and check all that apply

Date of Injury: _____ (mm/dd/yy)	Time of Injury: _____ ☐ am ☐ pm	Shift Began:_____ ☐ am ☐ pm	Accident happened while on duty: ☐ Yes ☐ No
Print Name (Last, First, MI):		Date of Birth: _____ (mm/dd/yy)	Employee ID Number:
Home Address: Street _____ City _____ State _____ Zip _____			Home Telephone Number: Cell Number:
First Full Lost Work Day Due to Injury: _____ (mm/dd/yy)		Regular Work Shift: from _____ ☐am ☐pm to _____ ☐am ☐pm	
Medical Care Provided on Day of Accident: ☐Yes ☐ No		Regular Days Off:	
Medical Care Provided By: Address/Phone:		Date Medical Care Provided: : _____ (mm/dd/yy)	
If medical care or lost work time is a result of a previous accident, indicate date of original accident: _____ (mm/dd/yy)			
☐Employee ☐ Student Employee		Job Title:	
Employee's Date of Hire: (mm/dd/yy)		Job Dept.:	
☐Full-Time ☐ Part-Time			

Specifically where did the injury occur (i.e. dining hall kitchen, Starbuck 1st floor stairwell, walkway in front of Facilities):

Part(s) of body injured (i.e. left arm, lower back):

Nature of Injury (i.e. cut, sprain, rash, pulled muscle, bruised):

What were you doing when the accident or exposure happened?

What were the weather conditions at the time of the accident?

Witnesses to accident:

Explain exactly how the accident or exposure happened and list the causes of the accident/exposure:

Personal Protective Equipment used? ☐ YES ☐ NO If YES, please note the types (safety glasses, nitrile gloves, cut resistant gloves, lab coat, safety shoes, etc.):

I confirm that the information furnished above is true and complete to the best of my knowledge:

Employee's/Student Employee's Signature: Date:

Supervisor's Signature: Date:

Supervisor to complete upon Employee's / Student Employee's return to work and fax to Human Resources at extension 5805 with physician's release (Employee must bring in release from Physician before resuming work)

☐ Return to **Modified Duty** Date: _____ (mm/dd/yy) ☐ Return to Full Duties Date: _____ (mm/dd/yy)

Supervisor's Signature: Date:

The following is a reminder about your responsibilities should you have an accident while in the workplace.

Your Responsibilities:

- Immediately report your injury to your Supervisor no matter how minor the injury.
- **Initial medical treatment and for 30 days following a work related injury must be managed through:**
  Occupational Medicine
  2388 Route 9
  Malta, NY 12020
  Phone: (518) 886-5412
  Monday - Friday: 8:00 am to 5:00 pm

  Directions from Skidmore College to Occupational Medicine: Take I-87 South to Exit 12. Follow NY-67 East to traffic circle. Take the first exit onto U.S. 9 S. Travel .5 miles and turn right on Knabner Rd into 2388 Professional Office Suites. Take first drive on left into Occupational Medicine parking lot. For the initial visit, Saratoga Taxi will take you there and pick you up.

If emergency medical treatment is required, seek treatment at Urgent Care/Wilton Medical Arts or Saratoga Hospital Emergency Room. If transportation is required contact Campus Safety at x5566.

- Inform your treating physician that the College's Workers Compensation insurance carrier is PMA Management Corp. Local pharmacies generally bill PMA directly for prescriptions filled related to your injury. Should they require you to pay at the time of purchase submit your receipts to Human Resources. Reimbursement will be sent to you directly from PMA.
- If your physician determines you're unable to work, provide written medical documentation to Human Resources and your supervisor
- Contact your supervisor at least once a week throughout your absence to advise him/her of your progress.
- Inform your treating physician that Skidmore College has a modified work program and may be able to make accommodations for any restrictions.
- Inform your supervisor when your physician will release you to return to work.
- Should you remain out of work beyond eligibility for supplemental pay by the College, you will be responsible to make all union dues/copayments directly to your Union.

Skidmore College's Responsibilities:

- Your Supervisor will work with you to complete an Accident Report of your workplace injury, and will submit it to the Human Resources department.
- Human Resources will, if applicable, submit the claim to the College's Workers' Compensation Insurance carrier who will set up a claim and assign a case number.
- Human Resources will provide you with the case number to share with your medical provider for ease in submitting bills and medical documentation.

Pay for Lost Work Time:

Depending on the length of time you are unable to work, you may be eligible to receive all or part of your regular salary from the College. Human Resources will advise you of your eligibility and guide you through the process should you need assistance.

Should you have questions or need additional information please contact Janet Wood (primary contact) at extension 5803.

SUPERVISORS' ACCIDENT INVESTIGATION REPORT

(To be completed by the Supervisor)

EMPLOYEE'S INFORMATION (type or print)			
INJURED EMPLOYEE'S NAME:	**ACCIDENT DATE:**	**ACCIDENT TIME:**	**ACCIDENT DAY OF WEEK:**
JOB TITLE AND DEPARTMENT:			
FIRST FULL LOST DAY DUE TO INJURY:	**□ EMPLOYEE □ STUDENT EMPLOYEE**	**□ FULL-TIME □ PART-TIME**	
IMMEDIATE SUPERVISOR:	**EXACT LOCATION OF ACCIDENT:**	**DATE REPORTED BY EMPLOYEE:**	
PERSON WHO RECEIVED FIRST NOTICE:	**WITNESSES:**		
DESCRIBE HOW THE INCIDENT OCCURRED:			
PART(S) OF BODY AFFECTED (include left or right. E.g. Left lower back):			
NATURE OF INJURY/ILLNESS (e.g. Strain, laceration, contusion, cut, sprain, rash pulled muscle):			
CAUSE OF INJURY (e.g. Slip or fall, struck by, cut or puncture, etc.):			
LIST ROOT CAUSES (UNDERLAYING): (e.g. Inadequate enforcement of work rules and procedures or lack of proper job procedures)			

SUPERVISOR'S ACCIDENT INVESTIGATION FORM, PAGE 3		
LIST THE ACTIONS THAT HAVE BEEN OR WILL BE TAKEN TO REMOVE CAUSES LIST ABOVE:	**ACCOUNTABLE PARTY:**	**COMPLETION DATE**

AS A SUPERVISOR, WHAT ADDITIONAL ACTIONS WILL YOU TAKE AS A RESULT OF THIS EMPLOYEE'S ACCIDENT?

INVESTIGATED BY:	**DATE:**	**REVIEWED BY:**	**DATE:**

Please Complete the Supervisor's Accident Investigation Form and forward to the Department Director within 24 hours (or as soon as practical thereafter) of the Date of Accident.