University at Buffalo The State University of New York

Workers' Compensation Accident/Injury Report Form

If you, as an employee, sustain an on-the-job injury or illness, you are covered under workers' compensation and are entitled to medical treatment at no cost. Please follow the procedure below.

- 1. When injured, notify your supervisor IMMEDIATELY.
- 2. Note: If the injury involves a needle stick or a cut from a sharp that could have been contaminated with blood or other bodily fluid, wash exposed area with soap and water, seek medical attention *immediately* and notify your supervisor. Inform your medical provider of the possibility of a blood borne contamination exposure. You and your department should contact EH&S immediately at 829-3301 to initiate investigation into the potential for blood borne infection. In addition, Employee should also notify Annette Lozo, the Workers Compensation Administrator at 645-7777. If your department has a biosafety exposure control plan already in place, please follow your departmental guidelines.
- **3.** If you need medical attention, go to the provider of your choice. Inform the provider that the injury is work related.
- 4. Follow the procedure below based upon your employee status.

State Employees only:

- Please complete the attached Accident/Injury Report Form in full.
- Contact the NYS Accident Reporting System (ARS) at 1-888-800-0029
- Enter the NYS ARS Incident Number under Part 2 of the Accident/Injury Report Form
- Fax the completed Accident/Injury Report Form to Annette Lozo at 645-2605 IMMEDIATELY.
- If you have questions, please contact Annette Lozo at 645-7777.
- The proper insurance carrier for State Employees is: The State Insurance Fund, 225 Oak Street, Buffalo, NY 14203 (716)851-2000.

Research Foundation Employees only:

- Please complete the attached Accident/Injury Report Form in full
- Fax the completed Accident/Injury Report Form to Annette Lozo at 645-2605 IMMEDIATELY.
- If you have questions, please contact Annette Lozo at 645-7777.
- Research Foundation Employees should <u>not</u> contact Chubb directly. Please call Annette Lozo at 645-7777.
- The proper insurance carrier for Research Foundation Employees is: Chubb First.

FSA Employees only: –Contact Sherry Wagner, 146 Fargo Quad, 645-0379.

<u>UB Foundation Employees only:</u> – Contact Anne Duggan, Center for Tomorrow, 645-3013

Sub-Board Employees only: - Contact Adria Moffatt, 341 Student Union, 645-2954

EMPLOYEE ACCIDENT/INJURY INFORMATION

	AL INFORMATION:	Demon	щ.		
Employee's Name: Job Title:					
Home Address:		Gender		e O Female	
Home Phone: ()	Supervi	isor's Name:		
Department:					
Dept. Address					
	(e.g. 9am-5pm): Full Time				
Part 2 - INCIDENT	DETAILS:				
		Incident Time:		_	
Location/Address of	f Incident (Bldg, Rm, Parking Lo	ot #):			
NATURE OF INJURY		•	LOCATION OF BODILY INJURY		
O Abrasion	O Dislocation	O Abdomen	O Face	O Leg	
O Bite	O Fracture	O Ankle		5	
O Bruise	O Laceration	O Back	J -	O Nose	
O Burn	O Sprain	O Chest	O Forearm	O Shoulder	
O Cut	O Needle Stick	O Ear	O Hand	O Teeth	
Othern		O Elbow		O Wrist	
Otner:		_ O Eye	O Knee		
		O Right Side		O Left Side	
	oyee doing when injured? (Be s				
What object or subs	tance directly harmed the emp	loyee? (e.g. "Concrete	floor," "chlorine	," "radial arm saw")	
Names of witnesses	S:				
Medical Treatment	Provided: (check if applicab	<u>le)</u>	Date:		
O First Aid by Staff	O Hospital O Persor	nal Physician O C	Other		
Name, Address and	Phone Number of Physician a	•			
,	,				
Date Notified Super	visor:	Time:			
NYS ARS Incident N	Number:(State Employees only –	will receive upon	speaking with ARS)	
Part 3 - CERTIFICA	TION: I certify that the above i	nformation is correct:			
Employee Signatu	ro	Date			
-mpioyee olynatu		Dale			