University at Buffalo
The State University of New York

Employee Accident or Injury Information

SUNY RF
The Research Foundation for
The State University of New York

Part 1 – Employee Information

Name: *(first, last)*

Home Address:

Home Phone: ( )

Work Status: *(Circle)* Part-time Full-time

Usual Work Days: *(e.g. Mon – Fri)*

Usual Work Hours: *(e.g. 9 a.m. – 5 p.m.)*

Line Number:

State Bargaining Unit: *(e.g. CSEA)*

Date of Birth:

Gender:

Person Number:

Job Title:

Supervisor's Name:

Department:

Department Address:

Department Phone:

Part 2 – Incident Details

Date and Time of Incident:	**Date and Time Supervisor Notified:**
Where Did the Incident Happen? *(Bldg, Room, Parking Lot #)*	**Time Lost?**
Nature of the Incident: *(Circle all that apply)* Abrasion Bite Bruise Burn Cut Dislocation Fracture Laceration Sprain Needlestick Other:	**Names of Witnesses:**
What Was the Employee Doing? *(Be specific)*	**Body Part(s) Affected:** *(Circle all that apply)* Right-side Left-side Abdomen Ankle Back Chest Ear Elbow Eye Face Finger Foot Forearm Hand Head Knee Leg Mouth Nose Shoulder Teeth Wrist Other:
How Did the Injury Occur?	**What Harmed the Employee?** *(e.g concrete floor, chlorine, radial arm saw)*
Medical Treatment Provided By:	**Name of Medical Service:**
Medical Treatment Date:	**NYS ARS Number (State only):**

Part 3 – Certification

I certify that the above information is correct:

Employee Signature *Date*

Print, Sign and Mail Form to: