

NEW YORK MEDICAL COLLEGE
INCIDENT REPORT

INSTRUCTIONS To be completed by
Employee/Supervisor at time of incident.

- 1st copy – Health Services Department
- 2nd copy – Human Resources Department
- 3rd copy – EHS Director
- 4th copy – Department Supervisor
- 5th copy – General Counsel (only if Non-Employee)
- 6th copy – Risk Management (only if Employee
lost time or has medical expenses)

EMPLOYEE INFORMATION

_____ **Employee** _____ **Student** _____ **Volunteer**
_____ **Other (specify)** _____

Name _____

Employee ID _____

Address _____

Tel. # _____

Age _____ **Sex** _____

Department _____

DETAILS OF INCIDENT

Date of Incident _____ **Time** _____ **am** _____ **pm**

Bldg. location/Room number of Incident _____

What were you doing when injured? Please be specific, identify tools, equipment or material you are using.

How did the accident or exposure occur? Please describe fully the events that resulted in injury or Occupational Disease. Tell what happened and how it happened. Use separate sheet if necessary.

WITNESSES

Name _____ **Address** _____ **Tel. #** _____

Name _____ **Address** _____ **Tel. #** _____

SIGNATURES

Employee _____ **Title** _____ **Date** _____ **Ext.** _____

Supervisor _____ **Title** _____ **Date** _____ **Ext.** _____

PHYSICIANS REPORT

Diagnosis as a result of accident _____

Immediate Treatment _____

X-rays Ordered _____ **Yes** _____ **No** **Time lost from work** _____ **Yes** _____ **No** _____ **Undetermined**

Employee may return to work _____ **Immediately** (or) on _____

Signature of Physician _____ **Date** _____

Please Print _____