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Employee Injury and Illness Incident Report

County of Westchester
148 Martine Avenue, Room 730
White Plains, NY 10601

All sections of the form must be completed. Please contact the Benefits Office with any questions: (914) 995-4834

Local Case ID#: _____ (To be assigned by the Finance Dept.)

EMPLOYEE'S PERSONAL INFORMATION

Name: _____ Age: _____ ☐ Male ☐ Female

Mailing Address: 10 Woods Road, Valhalla, NY 10595

Employee ID #: _____ Phone Number: (XXX) XXX-XXXX

EMPLOYEE'S INJURY OR ILLNESS

Date of Injury: _____

Time of day employee began work on date of injury _____ ☐ AM ☐ PM Time of Injury: _____ ☐ AM ☐ PM

Has the employee given you notice of injury/illness? ☐ Yes ☐ No

If yes, notice was given to _____ ☐ Orally ☐ In Writing Date of Notice: _____

If available, attach a copy of the employee's written notice and medical notes, and the employer's incident report.

Where did the injury/illness happen? _____

Was this location where the employee normally worked? ☐ Yes ☐ No If no, why was the employee there?

Employee's Supervisor: _____ Did supervisor see injury happen? ☐ Yes ☐ No ☐ Unknown

Did anyone else see the injury happen? ☐ Yes ☐ No ☐ Unknown If yes, give name(s): _____

What was the employee doing when he/she was injured or became ill? Be specific: _____

How did the injury/illness occur? Be Specific: _____

Explain fully the nature of the employee's injury/illness; list body parts affected. Be Specific: _____

Was an object, e.g. forklift, hammer, acid, involved in the injury/illness? ☐ Yes ☐ No

If yes, what was it? _____

Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No If yes:

☐ Employee's vehicle ☐ Employer vehicle ☐ Other vehicle License Plate #: _____

If employer's vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

Did the injury/illness result in the employee's death? ☐ Yes ☐ No If yes, date of death: _____

Name and address of nearest relative: _____

MEDICAL TREATMENT

What was the date of the employee's first treatment? _____ ☐ None Received ☐ Unknown

Where did the employee receive first medical treatment for this injury/illness? ☐ On Site ☐ Doctor's Office ☐ Emergency Room ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 Hours ☐ Unknown

Who treated the employee and where? _____

Is the employee still being treated for this injury/illness? ☐ Yes ☐ No ☐ Unknown

If yes, name and address of treating doctor(s): _____

To your knowledge, did the employee have another work-related injury to the same body part or a similar illness while working for you? ☐ Yes ☐ No If yes, name the doctor(s) who treated the previous injuries/illnesses if known:

RETURN TO WORK

Did the employee stop work because of his/her injury/illness? ☐ Yes ☐ No If yes, on what date: _____

Has the employee returned to work? ☐ Yes ☐ No

If yes, on what date: _____ ☐ Regular Duty ☐ Limited Duty

If the employee has returned to limited duty, what are his/her average gross earnings per week? _____

EMPLOYEE'S WORK INFORMATION ON THE DATE OF THE INJURY OR ILLNESS

Date the employee was hired: _____ What was the employee's job title? _____

What types of activities did the employee normally perform at work? Attach a job description if available

EMPLOYEE'S PAYROLL INFORMATION ON THE DATE OF THE INJURY OR ILLNESS

Employee's gross pay in an average week: _____

Did the employee receive lodging or tips in addition to pay? ☐ Yes ☐ No

Employee's job was: ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other _____

Which days of the week did the employee usually work? ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Was the employee paid for a full day on the day of the injury/illness? ☐ Yes ☐ No

Did you continue to pay the employee after the injury/illness (sick leave, vacation, disability, regular salary)? ☐ Yes ☐ No

ADDITIONAL INFORMATION

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who knowingly makes a false statement or representation as to a material fact in the course of reporting, investigation of or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment of benefit shall be guilty of a crime and subject to substantial fines and imprisonment.

The above information is true to the best of my knowledge and belief.

If prepared by the employer:

Signature of Person Preparing Form: _____ Date: _____

Print Name: _____ Title: _____

Phone Number: (XXX) XXX-XXXX

If prepared by a third party on behalf of the employer:

Signature of Person Preparing Form: _____ Date: _____

Print Name: _____ Title: _____

Phone Number: (XXX) XXX-XXXX

Company Name and Address: 10 Woods Road, Valhalla, NY 10595

Name of person who provided information necessary to prepare this form: _____

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Westchester County Department of Correction

Employee Notice of Claim

Regarding Incident of Accident / Injury / Illness

Information About You:

Name: _____ (Last) _____ (First) _____ (Middle Initial)

Home Address: 10 Woods Road (Street Address) Valhalla (City) NY (State) 10595 (Zip)

Home Phone: (XXX) XXX-XXXX Age: _____ Date of Birth: XX/XX/XXXX ☐ Male ☐ Female

Employee ID: _____ Job Title: _____

Regular Schedule Shift: _____ Years with the Department: _____ Division: _____

Information About the Incident:

Sector Supervisor at time of Incident: _____ Date: _____

Shift working at time of Incident: _____ Division: _____

Location of Incident: _____

Employee's statement as to how and why the accident / injury occurred. Statement is to be as complete and detailed as possible. (Continue to page 2 if more space is needed)

Is this a reoccurance of a prior injury? ☐ Yes ☐ No

If "Yes" give date of original injury: _____ Injured part of the body: _____

Witnesses (additional Witnesses add to page 2)

_____ (Name) 10 Woods Road, Valhalla, NY 10595 (Address)

_____ (Name) 10 Woods Road, Valhalla, NY 10595 (Address)

The foregoing statement is a true and accurate accounting of the accident/injury/illness which I am hereby claiming to be job related. I fully understant that a material flase statement will be considered to be willfully and fraudulently made and may result in disiplinary action and/or prosecution.

Immediate Disposition: Employee sent: ☐ Home ☐ Hospital ☐ Other: _____

_____ (Physician Name) _____ (Address)

_____ (Hospital Name) _____ (Address)

_____ (Employee Signature) _____ (Date)

_____ (Superivsor Signature) _____ (Date)

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Preliminary

Employee Injury Investigative Report

Investigator: _____ Shield: _____ Date: _____

WHEN

Date of accident: _____ Time: _____ Report to Supervisor delayed? ☐ Yes ☐ No

If yes, explain: _____

WHO

Person injured: _____ Age: _____

Occupation: _____ Length of employment: _____ Yrs _____ Mons

INJURY

Nature of injury and injured body part (i.e.: bruise, cut, complains of pain etc.)

Has employee returned to work? ☐ Yes ☐ No

WHERE

Exact location at which accident occurred: _____

WHAT

☐ Different Level Fall	☐ Struck By	☐ Strain / Overexertion	☐ Caught Between
☐ Same Level Fall	☐ Push / Pull	☐ Struck Against	☐ Burns
☐ Cut / Puncture	☐ Lift / Lower	☐ Motor Vehicle	☐ Carry / Hold
☐ Body Fluids	☐ Fumes, dust, gas		
☐ Other (describe): _____			

Was employee doing something other than required duties at time of accident? ☐ Yes ☐ No

If yes, what and why: _____

Description of accident (detail of what employee was doing and what physical objects, tolls, machines, structures or equipment were included:

WHY

What did the injured (or other person) do or fail to do that contributed directly to the accident?

What defective or otherwise unsafe conditions of tools, equipment, machinery, structures or physical objects contributed directly to the accident?

P R E V E N T I O N	What action should be done and by whom to prevent reoccurrence of this type of accident?
	What action are you taking to see this done?
☐	List any person's / employee's on the scene at the time of the accident or injury: Name: _____ Name: _____ Name: _____ Name: _____ Name: _____ Name: _____ Name: _____ Name: _____ **Referred to the Department of Correction's Special Investigation Unit on:** _____ Date Supervisor Signature: _____ Date: _____ Comments by Division Head or designee and Program Administrator Health & Safety based on information provided: _____ _____ _____ Name of Division Head / Designee Signature Date _____ _____ _____ Name of Program Admin. Health & Safety Signature Date

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
		XXX-XX-
Patient Address: 10 Woods Road, Valhalla, NY 10595		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
☑ TRIAD Group, PO Box 629, Armonk, NY 10504 and/or AMU (Must be checked for ALL claims) ☑ Westchester County District Attorney and/or WCPD For possible arrest/prosecution of inmate (assault)

9(a). Specific information to be released:
☑ Medical Record from (insert date) DATE INJURED to (insert date) DATE INJURED
☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
☐ Other: _____

Include: (*Indicate by Initialing*)
_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☑ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)
to discuss my health information with my attorney, or a governmental agency, listed here:
☑ TRIAD Group, PO Box 629, Armonk, NY 10504 and/or AMU ☑ Westchester County District Attorney and/or WCPD
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
		XXX-XX-
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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
☑ TRIAD Group, PO Box 629, Armonk, NY 10504 and/or AMU (Must be checked for ALL claims) ☑ Westchester County District Attorney and/or WCPD
For possible arrest/prosecution of inmate (assault)

9(a). Specific information to be released:
☑ Medical Record from (insert date) _____ to (insert date) _____
☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
☐ Other: _____
_____

Include: (*Indicate by Initialing*)
_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:
☑ TRIAD Group, PO Box 629, Armonk, NY 10504 and/or AMU ☑ Westchester County District Attorney and/or WCPD
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

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Body Fluid Exposure Incident Form

Employee Name: _____ Employee ID #: _____

Date of incident: _____ Time of incident: _____ Location of incident: _____

Date incident reported: _____

Details of incident: (check if continued on page 2 ☐)

_____

_____

_____

_____

_____

_____

_____

Was a Department Special Report Written? ☐ Yes ☐ No

Reason for concern:

☐ Contact with body fluids (Specify): _____

☐ Clothes soaked with blood or other body fluid (Specify): _____

☐ Stuck with needle or other sharp object (Specify): _____

☐ Location of puncture: _____

Have you received the Hepatitis B vaccine? ☐ Yes ☐ No If yes, date of third vaccination: _____

Were you wearing Protective Equipment? ☐ Yes ☐ No

If yes, what type was utilized? _____

If no protective equipment was utilized, why not?

_____

_____

_____

_____

If gloves were worn, were there any rips or tears? ☐ Yes ☐ No

The following forms must accompany this document:

Special Report – Preliminary Employee injury Investigative Report – Employee Notice of Claim – Medical Insurance Claim Form

Received by:

Sector Supervisor _____ Date: _____

Shift Commander _____ Date: _____

Assistant Warden _____ Date: _____

Continued from page 1