Syracuse University

Workers' Compensation Reporting Form

Please return completed form to Risk Management, 621 Skytop Road, Ste 100 or via email to slbuck01@syr.edu or fax 315.443.1154.

Keep a copy of this form for your records.

Injured Worker Information:

Name: _____

SUID: _____ **Department:**_____

Date of Birth: _____

Home Address: _____

Phone: _____

Date and time of incident: _____ **Time started work:**_____

Description of incident: Please be detailed and include where you were, what you were doing, how the accident happened and body parts:

_____

_____

_____

Signature/Date_____

Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which is a felony.

Note: If no treatment is indicated at the time of report, it is your responsibility to advise Risk Management of any medical treatment obtained after your report is filed.

Supervisor Statement:

Your description of the incident based on discussion with worker:

_____

_____

Contributing factors? Ex: Weather/Machinery or unsafe practices:

_____

Blood or body fluids contact? Who?_____

Lost time? RTW? _____

Medical Treatment? Where? When? _____

Witness?

_____

_____

Supervisor's Signature/Date:

_____

Additional Comments: Be sure to be clear about WHO is commenting!

_____

_____

_____

_____

_____

_____

Additional space on reverse of form if needed, for either employee or supervisor use.

If you have any questions or concerns, please contact: Sheera Buckley, Risk Management, 315.416.9066 or slbuck01@syr.edu.

For Risk Management Use Only: Indicate Y/N or actions and initial and date.
OSHA notification required: _____
Internal notifications needed: _____