



Office of Client Services
555 West 57th Street
11th Floor
New York, NY 10019

Employee's Notice Of Injury

Submission of this form serves as notice to the Research Foundation of your work-related injury. Please answer all questions as fully as possible, print your name and sign the form at the bottom, and forward the completed form to the Office of Client Services. Once this form is received and processed by Client Services, you will be sent a confirmation letter, further information and a claim number, if pertinent.

PERSONAL INFORMATION

Name: _____ Social Security Number: _____ - _____ - _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Mobile Phone: (_____) _____ - _____

Male ___ Female ___ Date of Birth: ____ - ____ - ____ E-Mail _____

JOB INFORMATION

Work Location and Campus: _____

Employment Status: FT ___ PT ___ Job Title: _____

Work Schedule (*include work days and hours*): _____

Supervisor's Name: _____ Contact #: (_____) _____ - _____

E-Mail _____

WITNESS INFORMATION

Name: _____

Address: _____

Telephone: (_____) _____ - _____ *List additional witnesses in comments section.*

INJURY INFORMATION

Date of Injury: _____ - _____ - _____ Time of Injury: _____ a.m. ___ p.m. ___

Exact work location where injury occurred:

Describe accident in detail including nature of injury and part of body injured:

Equipment, Material, or Substances involved:

MEDICAL INFORMATION

Prior injury or preexisting conditions:

Did you receive medical attention? Yes ___ No ___ If Yes, Please describe:

Provider's name, address and contact #:

Did you go to the hospital? Yes___ No___ If yes, did you go on your own? Yes___ No___

If yes, date you went to the hospital: ___/___/___

Was an ambulance used to transport you to a hospital? Yes ___ No ___

Hospital name and address:

Name and telephone of attending physician:

_____ (_____) _____ - _____

WORK ATTENDANCE

Have you lost time from work? Yes___ No___

If yes, dates of absence as a result of this injury:

Date you last worked: _____-_____-_____

Have you returned to work? Yes___ No___

If yes, date you returned to work: _____-_____-_____

ADDITIONAL COMMENTS or
ADDITIONAL WITNESS INFORMATION:

Print Employee's Name _____

Employee's Signature _____ Date _____-_____-_____