Employee's Notice Of Injury

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

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 _____-_____-_____