

[Reset Form](#)[Save Form](#)[Print Form](#)

## 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  
Mailing Address: 10 Woods Road, Valhalla, NY 10595 ☐ Female  
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: \_\_\_\_\_

Finance Dept. Benefits Office Completed by: \_\_\_\_\_ Date: \_\_\_\_\_