City of Norwich
Accident/Incident Reporting

Attached is the Employee Accident/Incident Report Packet:

Page 1: General instructions on Worker's Compensation information.

Page 2 and 3: The City of Norwich's Accident/Incident Report, please fill out this form completely and sign and date, please turn into supervisor by the end of the shift.

Page 4: C-3.3 Limited Release of Health Information (HIPAA) which authorizes the Workers Compensation board to receive information on your workers' compensation for injury.

Pages 2, 3 & 4 will need to be handed to your supervisor before the end of your shift. The letter and Page 1 are for your information.

If you have any questions, please call me at 607-334-1235 or email at lynnmurray@norwichnewyork.net

Thanks

Lynn Murray

Director of Human Resources

Generally, you can choose any health care provider as long as the provider is authorized by the Board. You can search for an authorized health care provider in your area using the "**Find a Doctor**" feature on the Board's website at **wcb.ny.gov**. You can also use occupational health clinics. However, if your employer's workers' compensation insurer has a Preferred Provider Organization (PPO) to provide care for workers' compensation injuries, you must get your initial treatment from the PPO network. If that insurer also has a pharmacy or diagnostic network, you must receive services within these networks. The insurer must tell you about its required provider networks and how to use them.

Benefits for Lost Wages

You are entitled to a portion of your lost wages, which must be paid promptly, if your injury affects you in one or more of the following ways:

1. It keeps you from work for more than seven days.
2. Part of your body is permanently disabled.
3. Your pay is reduced because you now work fewer hours or do other work.

You may hire an attorney or licensed representative for help with your claim, but it isn't required. The Board sets their fees, which will be deducted from your lost wages award. You or your family should not pay anything directly to your attorney or licensed representative.

If your case is disputed, you may receive disability benefits while the case is heard. To get a **Notice and Proof of Claim for Disability Benefits** (Form DB-450), visit **wcb.ny.gov**; call the Board for assistance; or visit a Board office. If the case is resolved in your favor, the disability benefits would be deducted from your lost wages award.

Help is Available

Sometimes you need help getting back to work. Your employer may have alternative or light duty assignments that enable you to work while you heal. An injury can also cause family or financial problems. The Board has vocational rehabilitation counselors and social workers to help. Call the Board for more information on available services and for assistance.

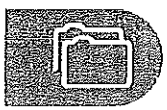
If you are concerned about dependency on opioid pain medications, please call the NYS OASAS HOPELine at **877-8-HOPENY (877-846-7369)**.

What's Next?

Your employer or its workers' compensation insurance carrier will contact you if your claim is accepted. When that happens, your health care providers will be paid and lost wage benefits begin. If your case is disputed, the Board will notify you about resolving the case and may request additional information if necessary.

IMPORTANT CONTACT INFORMATION

Workers' Compensation Board, Including Disability Benefits	**(877) 632-4996**	**general_information@wcb.ny.gov** **wcb.ny.gov**



The Board's eCase application enables you to view the contents of your case folder online. For general information or to register for eCase, please visit the Board's website at wcb.ny.gov.

NEW YORK STATE OF OPPORTUNITY. | Workers' Compensation Board

CITY OF NORWICH
EMPLOYEE ACCIDENT/INCIDENT REPORT

THIS SIDE TO BE FILLED OUT BY THE EMPLOYEE: Please print all information

BASIC INFORMATION

Date of Incident: ____/____/____ Time of Accident/Incident: _____ ☐ AM ☐ PM

Employee Name: _____

Address: _____

City: _____ County: _____ State: _____ Zipcode: _____

Home Phone #: _____ Cell Phone#: _____ Time shift began: _____ ☐ AM ☐ PM

Social Security #: _____ DOB: ____/____/____ Age: _____ Gender : ☐ Male ☐ Female

Department: _____ Job Title: _____

Date of Hire: ____/____/____ Employee Status: ☐ Full Time ☐ Part Time ☐ Per Diem · Shift Worked: 1__ 2__ 3__

Schedule *(check days normally worked)*: Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐

INJURY DETAILS

Type of Injury:

☐ Swelling/Redness ☐ Bruise/Contusion ☐ Laceration/Cut ☐ Burn ☐ Strain/or Sprain

☐ Exposure/Needlestick ☐ Possible Fracture ☐ Other, explain: _____

Area of Body Injured (check and circle all that apply):

☐ Head ☐ Neck ☐ Back – Upper/Middle/Lower ☐ Shoulder – R / L ☐ Arm – R / L

☐ Elbow-R /L ☐ Wrist /Hand/Finger – R / L (specify: _____) ☐ Hip – R / L ☐ Knee

☐ Ankle/Foot/Toe – R / L (specify: _____) ☐ Other: _____

DESCRIPTION OF INCIDENT

Where did the accident/incident occur? (e.g. resident room #, hallway, etc.) Be Specific: _____

Is this your normal work location? ☐ Yes ☐ No If no, why were you working there? _____

What were you doing when the accident/incident occurred? _____

How specifically did the injury occur? _____

Was equipment or an object involved? ☐ Yes ☐ No If yes, describe: _____

In your judgment, how could this have been prevented? _____

Did anyone witness the incident? ☐ Yes ☐ No

Name of Witness # 1: _____ Department: _____

Name of Witness #2: _____ Department: _____

Name of Supervisor: _____ **Did** your supervisor see the injury occur? ☐ Yes ☐ No

Was a motor vehicle involved in the incident? ☐ Yes ☐ No · If yes, describe: ☐ personal vehicle ☐ company vehicle ☐ other

REPORTING INFORMATION

Whom did you report the Accident/Incident to? _____

Date and time, you reported it: _____ Date and time filling out this paperwork _____

Did you receive an Injury Envelope? ☐ Yes ☐ No

COMPLETE BOTH SIDES

☐ Not seeking medical treatment *(Initial:* _____) -or- Date of first medical treatment: ____/____/____
Where will you be treated? ☐ On site ☐ Doctor's Office ☐ Emergency Room ☐ Clinic/Hospital/Urgent Care
Name of Treating Doctor/facility: _____
Address & Telephone #: _____

Provide any known additional information related to your treatment for this injury: _____

Have you had a previous work-related injury to the same body part or similar illness while employed? ☐ Yes ☐ No
If yes, explain (including treating physician's name): _____

By signing below, I verify that the information provided in this report is true, complete and accurate to the best of my knowledge. I understand that any willful omission of &/or falsification is fraudulent and may be punishable to the fullest extent under Section 114a of the NYS Workers Compensation Law. Furthermore, I also understand that completion of this document does not imply or guarantee acceptance of this claim by my employer or insurance carrier.

Signature: _____ Date: ____/____/____

THIS FORM MUST BE HAND-DELIVERED TO YOUR SUPERVISOR

FOR SUPERVISOR COMPLETION

Date Received: ____/____/____ Signature: _____
Will the employee complete the shift? ☐Yes ☐No · Did you release the employee to leave early? ☐Yes ☐No
Did you remind employee to follow-up with HR the next business day? ☐ Yes ☐ No
Additional supervisor comments, additional information: (attach additional documentation as needed)_____

FORM MUST BE HANDED INTO HUMAN RESOURCES BY END OF SHIFT

FOR OFFICE USE

Date Received: ____/____/____ Signature: _____

INJURY MANAGEMENT FOLLOW UP

Comments: _____

Signature: _____ Date: ____/____/____
Comments: _____

Signature: _____ Date: ____/____/____

7/13

NEW YORK STATE | Workers' Compensation Board

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

WCB Case No. *(if you know it)*:_____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:_____ 2. Social Security Number:____-____-____
3. Mailing Address: _____
4. Date of Birth: ____/____/____ 5. Date of the current injury/illness: ____/____/____
6. Current injury/illness, including all body parts injured:_____
7. Your legal representative's name and address (if any):_____

☐ *Check here if you allow your health care provider(s) to release mental health care information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:_____ 2. Phone Number: (____)_____
3. Mailing Address: _____
4. Other provider (if any):_____ 5. Phone Number: (____)_____
6. Mailing Address:_____

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____
Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

_____
Your name Relationship to Claimant Signature (ink only -- use blue ballpoint pen, if possible.) Date

Versión en español al reverso de la forma.