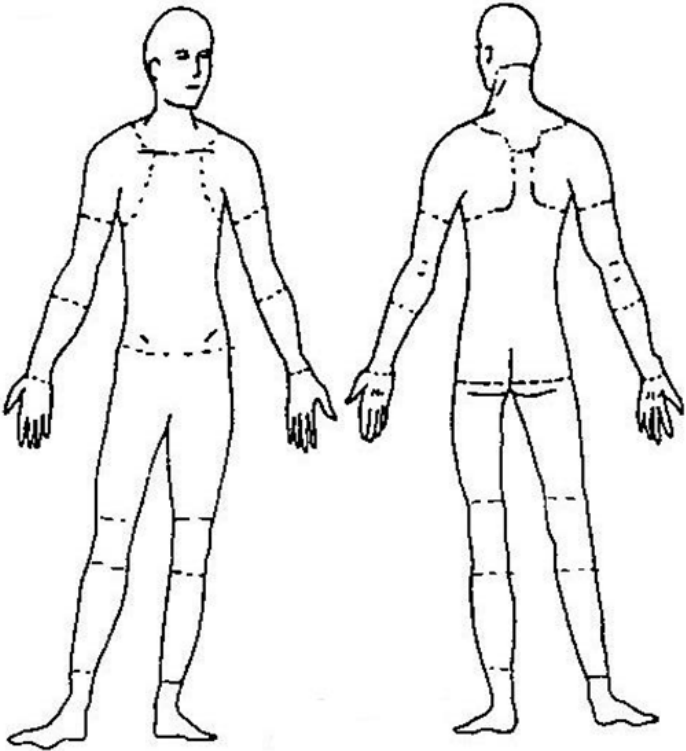


Injury/Illness Reporting Form



Incident Description		
Incident Type <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Near miss <input type="checkbox"/> Property Damage* <small>*See Property Damage Reporting Form</small>		
Has the SCA Been Notified <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, to whom and by what method?	
School Name and Address		
Borough	Contract Number	
Date of Incident	Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Date of Report
Name of Injured	Job Title	
Address	Date of Birth	SSN
Employer		Supervisor
Person Injured is <input type="checkbox"/> Contractor <input type="checkbox"/> Vendor <input type="checkbox"/> Pedestrian <input type="checkbox"/> DOE Employee <input type="checkbox"/> Student <input type="checkbox"/> Other		
Safety Training <input type="checkbox"/> 10 Hour OSHA <input type="checkbox"/> 30 Hour OSHA <input type="checkbox"/> Safety Orientation <input type="checkbox"/> Scaffold		
If a supervisor has been notified, provide their name and contact information.		
Exact Location of Incident	Has the Location Been Secured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the Incident Involve Equipment <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the Equipment Been Secured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Equipment	Make/Model Serial Number	If Equipment was secured, where?
Was PPE provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, by whom and what type?	
Witness Contact Information		
Witness Name and Employer	Home Address	Phone and Email
Incident Description		
Provide a brief description of how the incident occurred. Describe the task being performed by the involved party when they claim to have been injured or became ill. Include specifics regarding equipment, structure, tools, materials, objects, positions, distances, and sequence of events.		
Were Emergency Services Called <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> NYPD Which Precinct?	<input type="checkbox"/> EMS Which Hospital?
		<input type="checkbox"/> FDNY Which Department?

Injured Party Signature	Date
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Injury Description		
Name of Injured	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age
Employer	Job Title at Time of Incident	
Was the injured transported to the hospital for medical attention? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?		
Part of body Affected – place an “X” to all that apply 		Nature of Injury <input type="checkbox"/> Abrasion, scrapes <input type="checkbox"/> Amputation <input type="checkbox"/> Broken Bone <input type="checkbox"/> Bruise <input type="checkbox"/> Burn (heat) <input type="checkbox"/> Burn (chemical) <input type="checkbox"/> Concussion <input type="checkbox"/> Crushing injury <input type="checkbox"/> Cut, laceration, puncture <input type="checkbox"/> Hernia <input type="checkbox"/> Illness <input type="checkbox"/> Sprain, Strain <input type="checkbox"/> Other
List Injured Body Parts		
Employee Status <input type="checkbox"/> Regular Full Time <input type="checkbox"/> Regular Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary		
Months with Employer	Months Doing This Job	
Preparer Information		
Name of Individual Who Prepared Report	Employer	
Phone and Email	Signature and Date	
Email this form to noticeofaccident@nycsca.org . For urgent matters call (718) 472-8778.		

Injured Party Signature	Date
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