SUNY SCHENECTADY
COUNTY COMMUNITY COLLEGE

WORKERS' COMPENSATION REPORT OF INJURY/ILLNESS

Workers' Compensation Information: TRIAD GROUP, LLC administers our Workers' Compensation Benefits. Please provide the following contact information to your physician, if asked.

TRIAD GROUP, LLC
400 Jordan Road, 3rd Floor
Troy, New York 12180
Phone: 800-337-7419
Rx prescriptions processed through PMSI/TMESYS (800) 964-2531
Diagnostic Testing scheduled through One Call Medical (800) 872-2875

INSTRUCTIONS: Injured or ill employee (or designee) should complete and return the following Workers' Compensation Report of Injury/Illness to Human Resources within 24 hours of the injury/illness. ***NOTE:*** WORKERS' COMPENSATION BENEFITS WILL NOT BE PAID WITHOUT PROOF OF MEDICAL DISABILITY. If you require immediate medical attention and are unable to complete this form before leaving your work site, please complete and return to Human Resources as soon as possible. If you have any questions regarding this form please call Human Resources at 518-381-1218.

PERSONAL INFORMATION

Name: ____ Date of Birth: _____/_____ /_____

Address: ____

Social Security Number: _____________________ Phone Number: ( ) ________________ Gender: ❍ Male ❍ Female

INJURY OR ILLNESS INFORMATION

Date of Injury: _____/_____ /_____ Time of injury: _______ ❍ AM ❍ PM

Where did the injury/illness happen? ____

Is this a normal work location? ❍ Yes ❍ No If no, please explain: ____

Supervisor Name/Phone Number: ____

Did supervisor see injury happen? ❍ Yes ❍ No ❍ Unknown

Did anyone else see the injury happen? ❍ Yes ❍ No ❍ Unknown If yes, give name(s) and phone number(s):

____

____

How did the injury/illness occur? (EXAMPLE: THE EMPLOYEE TRIPPED OVER A PIPE AND FELL ON THE FLOOR): _______________

____

Explain the nature of the injury/illness; list body parts affected (EXAMPLE: TWISTED LEFT ANKLE AND CUT TO FOREHEAD):

____

____

Was an object (EXAMPLE: FORKLIFT, HAMMER, ACID) involved in the injury/illness? ❍ Yes ❍ No If yes, what was it? ________

____

Was there property damage as a result of this accident: ❍ Yes ❍ No If yes, please explain:

____

Was the injury the result of the use or operation of a licensed motor vehicle? ❍ Yes ❍ No

If yes, was it the employee's vehicle ❍ / employer's vehicle ❍/ other vehicle ❍ Please describe: ________________________

Year/Make/Model (if known):_______________________ License plate number (if known): ____________________________

Insurance Carrier Information (NAME, ADDRESS, PHONE NUMBER, POLICY NUMBER):

____

____

____

MEDICAL TREATMENT INFORMATION

Date of the first treatment? _____/______ /______ ❍ None received ❍ Unknown

Where was medical treatment for this injury/illness received?

❍ On Site ❍ Doctor's Office ❍ Emergency Room ❍ Urgent Care ❍ Hospital stay over 24 hours

Please provide the Physicians name, Facility name, address and phone number:

____

____

Are you still being treated for this injury/illness? ❍ Yes ❍ No ❍ Unknown

If yes, name, address and phone number of treating doctor(s):
____

____

Name of Person Completing Form: ____ Phone number: ( )_____________

Signature of Person Completing Form: ____ Date: _________________________

WORKERS' COMPENSATION REPORT OF INJURY/ILLNESS AUTHORIZATION FORM

Medical Authorization (Must be signed by employee)

I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested. I certify that all of the information I furnish in support of this claim is true and correct.

____ __________________________

Employee's Signature Date

Insurance Fraud Declaration (Must be signed by employee)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. I understand that my signature herein constitutes my affirmation that I am applying for Worker's Compensation benefits pursuant to law, that I have made no false claims or statements or concealed any material facts in order to receive said benefits and that doing so would make me liable for civil or criminal penalties, including jail.

____ __________________________

Employee's Signature Date

SICK LEAVE PAY ELECTION FOR WORKERS' COMPENSATION

_____ If applicable, I hereby elect to receive sick leave pay in accordance with my collective bargaining agreement which covers disability leave compensation under the Workers' Compensation Law.

OR

_____ If applicable, I hereby elect to receive Workers' Compensation benefits directly following approval for same.

________________________________ __________________________

Employee Signature Date

____

Employee Name (print)

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EMPLOYER FORM

The following section should be completed by the employer.

RETURN TO WORK

Employee Name: ____ Date of Hire: ______ /______ /____ __

Current Job Title: ____ Current Department: ________________________

❍ Attach Job Description Average Weekly Gross Pay: $____________________

Employee is ❍ Full Time ❍ Part Time ❍ Temporary ❍ Other If other, please describe:_______________________

Employee is normally scheduled to work on ❍ Mon ❍ Tues ❍ Wed ❍ Thurs ❍ Fri ❍ Sat ❍ Sun

****

Date Report of Injury provided to Human Resources: ______ /______ /______

Did the employee stop work because of his/her injury/illness? ❍ Yes ❍ No

If yes, employee's last day worked: _____/______ /______

Employee paid for a full day on the day of the injury/illness? ❍ Yes ❍ No

Did the injury/illness result in a death? ❍ Yes ❍ No If yes, date of death: ____/_____/______

Nearest Relative (NAME, ADDRESS, PHONE NUMBER): ____

Has the employee returned to work? ❍ Yes ❍ No If yes, return to work date: _____/______ /______

❍ Regular duty ❍ Limited duty

If the employee has returned to limited duty, what are his/her average gross earnings per week? $______________________

Did the employee have another work-related injury to the same body part or similar illness while working for you? ❍ Yes ❍ No

Name of Person Completing Employer Section: ________________________________ Phone number: ( )____________

Signature of Person Completing Employer Section: ________________________________ Date: ____________________