**ONONDAGA COUNTY**

**ACCIDENT/ILLNESS REPORT**

Accident Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time Occurred \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Reported \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Injured Person Name (F, L, M) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M  F  D.O.B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_  
E-mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_  
Home Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Hire \_\_\_\_\_\_\_\_\_\_\_\_  Full Time  Part Time  Seasonal Wages/Hour \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Days Worked:  M  T  W  TH  F  SA  SU  
Time Work Started Day of Accident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
How Long Employed in Current Occupation \_\_\_\_\_\_\_\_\_\_\_\_ Dept. Where Employed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
What is the location of this injury(County Bldg., or site physical address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E M P L O Y E E**

**C O M P L E T E D**

**S E C T I O N**

Person Reported to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Orally  Writing  
Witness Name(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# (\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_ Statement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Medical Care?  Yes  No Treated in Emergency Room?  Yes  No  
Hospitalized Overnight?  Yes  No Prior Injury Date?  Yes  No  
Name & Address of Treating Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Health Facility Name & Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| Nature of Injury | What was the employee doing before the incident occurred? Describe the activity as well as the tools, equipment, or material  the employee was using. Be specific. Example: “Climbing ladder while carrying roofing material”; “Spraying chlorine from hand sprayer.” |
| What happened? Tell us how the injury occurred. Example: “When ladder slipped on wet floor, worker fell 20 feet.”; “Worker  was sprayed with chlorine when gasket broke during replacement.” |
| What was the injury or illness? Tell us the part of the body that was affected and how it was affected; be more specific than  “hurt” “pain” or “sore.” Examples: “strained back”; “chemical burn, hand.” |
| Cause of Accident | What object or substance directly harmed the employee? Example: “concrete floor”; “radial arm saw”; “chlorine” |

***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 in support of this claim is true and correct.

DATE EMPLOYEE’S SIGNATURE

***Insurance Fraud Declaration*:** Any person who knowingly, and with intent to defraud any insurance company, or other person that 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 statement or conceal any material facts in order to receive said benefits and that doing so would make me liable for civil or criminal penalties, including jail.

DATE EMPLOYEE’S SIGNATURE

**OSHA**

1. Did the event or exposure occur on the employer’s premises?  Yes  No 7. Failure to use safeguards?  Yes No   
2. Did the event or exposure result in any med. treatment or death?  Yes  No 8. Failure to follow rules?  Yes No  
3. Was medical treatment more than just first aid involved?  Yes  No 9. Privacy case (HIV, Hepatitis)?  Yes No  
4. Did the Employee lose Consciousness?  Yes  No  
5. Does the injury or illness require transfer to another job?  Yes  No  
6. Did sharps object cause the accident?  \*Yes  No \*Sharps brand/make?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**S U P V**

**“Onondaga County has checked Yes for one of the OSHA 29CFR 1904.7 criteria which indicates Onondaga County has determined the accident to be OSHA recordable”**

Has cause of accident been corrected?  Yes  No If yes, how\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What steps have been taken to prevent similar incidents? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What steps should be taken to prevent a recurrence? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any property, product, or equipment damage?  Yes  No Motor Vehicle Accident?  Yes  No

If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ongoing medical treatment for accident?  Yes  No Date Stopped Work Due to Accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Paid for Full Day on Day of Accident?  Yes  No Salary Continuation?  Yes  No

Date Returned to Work (RTW) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  RTW Full Duty  RTW Restricted Duty

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| --- |
| *IMMEDIATE SUPERVISOR’S STATEMENT* (must always be completed): Supervisors must investigate all injuries/illnesses. Describe how injury/illness occurred, what was employee doing when injured, how injury/illness is job related, and verify all witnesses. Please state actions taken to prevent this type of injury/illness from occurring in the future.  DATE IMMEDIATE SUPERVISOR’S SIGNATURE   DATE SUPERVISOR/COMMAND OFFICER’S SIGNATURE  **S U P E R V I S O R**  **C O M P L E T ED**  **S E C T I O N**  DATE DEPT. HEAD/DESIGNEE’S SIGNATURE |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPT. USE ONLY** | | | | (DEPARTMENT PERSONNEL/CLERK COMPLETE APPLICABLE SECTIONS) | | | |
| Employer’s Name | | Employer’s Mailing Address | | | | Dept Code | |
| Fatal Case | Date of Death | Name/Address of Nearest Relative | | | Relationship | |  |
| Average Earnings Per Week | | | Total Earnings Paid During 52 Weeks Prior to Date of Accident (Include Bonuses, Overtime, Value of Lodging, Etc.) | | | | |

**INSTRUCTIONS**

**Employee:** WORKERS’ COMPENSATION BENEFITS WILL NOT BE MADE WITHOUT PROOF OF MEDICAL DISABILITY.

Be sure to sign both the medical authorization section, the insurance fraud declaration, and check the box if you do not want your name listed on the annual summary log due to job related illness. All injuries will be listed. It is important that you sign **ALL** places in order to process your claim and allow the release of medical records regarding this claim. **FAILURE TO SIGN MAY DELAY ACCEPTANCE OF CLAIM OR RESULT IN A CONTROVERTED CASE.**

Upon completion of the employee section, please forward this form to your supervisor.

**Supervisor:** Please be sure you complete the Supervisor’s statement as accurately as possible. Only state those facts you have actual knowledge of.

Otherwise, it is permissible to use the words “alleges” or “employee states.”

Upon completion of the Employee and Supervisor sections, please forward this form to your department administration office.

**Department Personnel:** Please be certain that you complete the five lines at the top of page 2 of the Injury/Illness Report.

1. TRIAD GROUP will receive all Injury and Illness Reports. TRIAD GROUP will determine if a case is a medical only claim, a lost time claim, or if any other action is required.

2. Please instruct employees to advise treating doctors and hospitals to send all medical reports and bills to: TRIAD GROUP, 400 Jordan Rd, Troy NY 12180

Main Number: (800) 337-7419

3. All medical bills approved by TRIAD GROUP will be paid per the Medical Fee and Hospital Rate Schedule.

4. The employee has free choice of doctor or hospital as long as the doctor or hospital is recognized and approved by the Workers’ Compensation Board. The attending Medical Doctor must submit medical reports in accordance with the Workers’ Compensation Law to TRIAD GROUP. The doctor or other medical providers may not submit bills to or collect fees from the employee.

The County has the right to have the employee examined by a doctor of their choice at a time and place reasonable to the employee.

**WORKERS’ COMPENSATION BENEFITS WILL NOT BE PAID WITHOUT MEDICAL PROOF OF DISABILITY.**

**CLAIMANT’S AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (Pursuant to HIPAA)**

INSTRUCTIONS

**To the Claimant**: The Health insurance Portability and Accountability Act of 1996 (HIPAA) set standards for guaranteeing the privacy of individually identifiable health information and the confidentiality of patient medical records. By completing and signing this form, you authorize your health care provider to file medical reports with the parties that you choose (such as the Workers’ Compensation Board, your

employer’s insurance carrier/claims administrator, your attorney or representative, etc.) by checking the appropriate boxes below.

You have the right to refuse to sign this authorization. If you sign you have the right to revoke this Authorization at any time by mailing a request to revoke to the health care provider. You have the right to receive a copy of this Authorization.

**IMPORTANT: Failure of execute this authorization may interfere with your ability to obtain workers’ compensation benefits.**

Claimant’s Name Claimant’s Social Security Number Claimant’s Date of Birth

I, , hereby authorize my treating health care provider(s) to disclose the following described health information:

Any medical records with the exception of (1) any mental health records protected under Section 33.13 of the NYS Mental

Hygiene Law and (2) HIV/AIDS related information protected under Article 27-f of the NYS Public Health law

This information can be disclosed to the following parties: (check all that apply, give names and addresses, if known)

New York State Workers’ Compensation Board

My current/former employer

Workers’ Compensation insurance carrier(s)

Third Party Administrator (and its authorized representatives)

TRIAD GROUP, 400 Jordan Rd, Troy NY 12180

My attorney/licensed representative

The Uninsured Employer’s Fund (this fund is responsible for paying the medical bills and lost wage benefits when an employer is uninsured.)

Special Funds Conservation Committee (for cases under Section 25-a or 15-8 of the Workers’ Compensation Law)

**Section 25-a**: If your claim is being reopened after being previously closed, the Special und for Reopened Cases may be responsible for paying your medical bills and lost wage benefits

**Section 15-8**: If you had a medical condition that existed prior to this injury, the Special Fund for Second Injuries may be responsible for reimbursing your employer’s insurance carrier after a period of time has elapsed.

**Redisclosure**: I understand that once the above-referenced health care provider discloses health information based on this

Authorization, that health information is no longer protected by HIPAA and the Privacy Rule.

**Expiration Date**: This authorization expires upon the final closing of the workers’ compensation claim(s) for which it is executed.

**I have had the opportunity to review and understand the content of this Authorization. By signing this Authorization, I**

**confirm it accurately reflects my wishes.**

Printed Name of Claimant Signature of Claimant or Legal Representative Date

If authorization is signed by a legal representative on behalf of the claimant, state relationship to the claimant and basis for authority e.g. claimant is a minor, patient is deceased and representative is the claimant in a workers’ compensation proceeding or represents the estate).



