State University of New York
College of Environmental Science and Forestry

Instructions on completing the INJURY/ILLNESS Report

NY STATE Employees

1. Call 1-888-800-0029 within 24 hours to report the incident (ARS number assigned).
2. Complete Part 1 in full and include the ARS incident number.
3. Ensure necessary signatures.
4. Submit injury/illness form to Human Resources (HR) to initiate Workers' Comp claim.
5. Do not use NYS health insurance for the claim—inform provider it is a work-related injury. Send bills to:
    - NYSIF, PO Box 66699, Albany, NY 12206. Policy No. 240960
6. Notify your supervisor and Human Resources (HR) of any time off or medical treatment related to the incident. Submit return-to-work documentation to HR 48 hours before return date.

RESEARCH FOUNDATION Employees

1. Complete Part 1 in full.
2. Ensure necessary signatures.
3. Submit injury/illness form to HR to initiate Workers' Comp claim.
4. Do not use personal health insurance—send bills to:
    - Chubb Insurance, PO Box 4700, Chesapeake, VA 23327. Policy No. 71644923
5. Notify your supervisor and Human Resources (HR) of any time off or medical treatment related to the incident. Submit return-to-work documentation to HR 48 hours before return.

Supervisors

1. Complete Part 2 and verify the form is fully complete.
2. Keep HR informed of employees' work status and correspondence.

Witnesses

1. Complete Part 3.
2. Return to employee for submission.

Revised May 2025

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SUNY-ESF INJURY/ILLNESS REPORT FORM

CHECK APPLICABLE CATEGORY	Instructions
☐ **EMPLOYEE** (UUP, CSEA, PBA, NYSCOBA, M/C)	Complete this form and call 1-888-800-0029 to report the injury/illness.
☐ **STATE STUDENT EMPLOYEE** (Graduate Assistant, Work-Study, Student Assistant)	Complete this form and call 1-888-800-0029 to report the injury/illness.
☐ **RESEARCH FOUNDATION EMPLOYEE**	Complete this form and submit to HR.
☐ **RESEARCH FOUNDATION STUDENT EMPLOYEE** (Research Project Assistant, etc.)	Complete this form and submit to HR.
☐ **OTHER** (Specify)**:** _____	Complete this form and forward to Human Resources, 216 Bray Hall.

Students (non-work-related injury): Complete this form and forward to Environmental Health & Safety, 19 Bray Hall.

Part 1: Employee Section

Name:		ARS/Incident #:	Department:
Date of Hire:	Date of Birth:	Gender: ☐ Female ☐ Male ☐X	
Address:			Please Check One: ☐ CSEA ☐ M/C ☐ UUP ☐ Research ☐ NYSCOPBA Foundation ☐ PBANYS
Phone:		Email:	
Date of Injury/Illness:	Time of Injury/Illness:	Date of Report:	Time Shift Began:
Pass Days (days off): ☐Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat		Job Title:	
First Person You Told of Accident:		Provide Name(s) of Any Witness(es):	
Location and Address of Occurrence:		Were You Working Overtime at Time of Injury or Exposure? ☐ Yes ☐ No	

Describe in Detail Your Injury and What You Were Doing When the Injury/Illness Occurred:

What Tools, Equipment, Objects, or Substances Were Involved?

Was Medical Assistance Rendered? ☐No ☐Yes – by Whom & When?
First aid only ☐ No ☐ Yes
Did you go to the Emergency Room? ☐ No ☐ Yes
Were you Admitted to the Hospital? ☐ No ☐ Yes

Treating Healthcare Provider Info for Injury– Name, Address and Phone #

Signature of Injured Person:_____**Date:**_____

Revised May 2025

Part 1 continued

Please check all that apply with respect to your injury/illness. You should have at least **one box checked** in each column

Body Part(s)	Nature of Injury/Illness	Event(s)/Cause(s)	Source(s)/Exposure(s)
☐ Abdomen	☐ Abrasions/scrapes/scratch	☐ Alleged Assault	☐ Animal
☐ Ankle ☐ Left ☐ Right	☐ Allergic Reaction	☐ Alleged Harassment	☐ Bacteria/Virus/Fungus
☐ Arm ☐ Left ☐ Right	☐ Bite(s)/Sting(s)	☐ Bending/Stooping	☐ Bed/Stand
☐ Back, Inc Spine	☐ Breathing Difficulty	☐ Climbing	☐ Blood/Body Fluids
☐ Body Systems	☐ Burn(s)	☐ Collapse	☐ Body Movement/Motion
☐ Breast ☐ Left ☐ Right	☐ Chest Pain	☐ Collided with	☐ Broken Glass/ Sharp Object
☐ Buttock(s)	☐ Head Injury	☐ Computer Use	☐ Buildings and Premises
☐ Chest	☐ Contusion(s)/Bruise(s)	☐ Construction	☐ Carts/Dollies
☐ Ear ☐ Left ☐ Right	☐ Crush Injury	☐ Contact with	☐ Chemical(s) Specify:_____
☐ Elbow ☐ Left ☐ Right	☐ Repetitive Strain/Sprain	☐ Fall	☐ Cleaning Agent Specify:____
☐ Eye ☐ Left ☐ Right	☐ Death	☐ Grounds work	☐ Computer
☐ Face	☐ Dislocation(s)	☐ Housekeeping	☐ Co Worker
☐ Finger(s) ☐ Left ☐ Right	☐ Dizziness	☐ Ingestion	☐ Dust/Airborne Particles
☐ Foot ☐ Left ☐ Right	☐ Electric Shock	☐ Inhalation	☐ Electricity
☐ Groin	☐ Exposure(s)	☐ Kneeling	☐ Elevator
☐ Hand ☐ Left ☐ Right	☐ Foreign Body	☐ Lifting	☐ Equipment Specify:_____
☐ Head	☐ Broken Bone	☐ Material Handling	☐ Explosion and/or Fire
☐ Hip ☐ Left ☐ Right	☐ Headache	☐ Needle Stick	☐ Falling Object(s)
☐ Internal Organ(s)	☐ Hearing Disorder/loss	☐ Overexertion	☐ Floor
☐ Knee ☐ Left ☐ Right	☐ Hernia	☐ Overextension	☐ Friction
☐ Leg ☐ Left ☐ Right	☐ Infectious/Parasitic Disease	☐ Pinched	☐ Fume(s)/Noxious Odor(s)
☐ Lip(s)	☐ Internal Organ Injury	☐ Pulling	☐ Gas(es)
☐ Lung ☐ Left ☐ Right	☐ Laceration(s)/Cut(s)	☐ Pushing	☐ Ground
☐ Mouth	☐ Loss of Consciousness	☐ Reaching	☐ Hand Tool(s)
☐ Neck	☐ Mental Disorder/Stress/Anxiety	☐ Repetitive Work	☐ Hot or Cold Temperature
☐ Nose ☐ Left ☐ Right	☐ Muscle/Tendon/Ligament/Joint/Inj	☐ Restraining Person	☐ Insect(s)
☐ Pelvis	☐ Nausea/Vomiting	☐ Slip/Trip/Loss of Bal w/o Fall	☐ Instrument(s)
☐ Ribs ☐ Left ☐ Right	☐ No Apparent Injury	☐ Spill	☐ Lighting
☐ Shoulder ☐ Left ☐ Right	☐ Numbness/Tingling	☐ Spray/Splash	☐ Loud Noise
☐ Skin	☐ Pain	☐ Struck Against	☐ Motor Vehicle
☐ Stomach	☐ Paralysis/Weakness	☐ Struck By	☐ Office Equipment
☐ Tailbone	☐ Poisoning		☐ Organic Compounds
☐ Teeth	☐ Puncture(s)		☐ Paints/Solvents
☐ Thigh ☐ Left ☐ Right	☐ Resp. Distress/ Shortness of Breath		☐ Parking Garage
☐ Thumb ☐ Left ☐ Right	☐ Splinter(s)		☐ Parking Lot
☐ Toe(s) ☐ Left ☐ Right	☐ Sprain(s)/Strain(s)		☐ Radiation
☐ Tongue	☐ Swelling		☐ Scaffold
☐ Wrist ☐ Left ☐ Right	☐ Visual Disturbance(s)		☐ Sharp Object Specify:
			☐ Sidewalk/Curb/Pavement
			☐ Snow/Ice
			☐ Stairwell
			☐ Steam
			☐ Student
			☐ Vibration
			☐ Visitor
			☐ Volunteer
			☐ Water/Liquid
			☐ Window/Door
☐ Other - List:	☐ Other - List:	☐ Other - List:	☐ Other - List:

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SUNY-ESF INJURY/ILLNESS REPORT FORM

Part 2: Supervisor Section	
Supervisor (Print Name):	Date and Time You Were Notified of Injury/Illness: Date: Time:
Did Employee Continue Working? ☐No ☐Yes If NO, Date Left Work:	First Full Date of Absence: Date Employee Returned:
Supervisor Comments:	

Supervisor Signature: **Date:**

Part 3: Witness Section	
Witness (Print Name):	Date and time of injury/illness: Date: Time:
Witness Comments:	

Witness Signature: **Date:**

Submit this completed form to the Office of Human Resources, Room 216 Bray Hall

Revised May 2025