Administrative Update

SUNY ESF INJURY/ILLNESS REPORT

Check applicable category, then complete form below:

- **EMPLOYEE** (injury/illness related to employment as checked below)

☐ UUP, CSEA, PBA-represented or Management/Confidential *complete this form, and call 1-888-800-0029 to report an injury and/or illness.*

☐ STATE STUDENT EMPLOYEE
(Graduate Assistant, Work-Study, Student Assistant) *complete this form, and call 1-888-800-0029 to report an injury and/or illness.*

☐ RESEARCH FOUNDATION EMPLOYEE

☐ RESEARCH FOUNDATION STUDENT EMPLOYEE (Research Project Assistant, Research Aide, Senior Research Aide)

- **OTHER** Official Volunteer or other (specify) _____

Employees/Others- Complete this form for any work-related injury/illness and forward to Human Resources, 216 Bray Hall. State Employees call 1-888-800-0029 to report an injury and/or illness.

- **STUDENT** (injury/illness not related to employment)

Students-complete this form and forward to Environmental Health & Safety, 19 Bray Hall.

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Employee Name: _____

Home telephone: (_____) _____

Home address: (Street, P.O. Box, City, State, Zip)

_____

_____

If injury:

Date and time injury occurred _____/_____/_____ _____am _____ pm

Place of injury: _____

***If illness*:**

Date of exposure or symptoms _____/_____/_____

If injury/illness is related to employment:

Unit where employed:_____Location:_____

Regular work schedule: _____

Were you on duty at the time the accident/exposure occurred? YES☐ or NO☐

Were you working overtime at time of injury or exposure? YES☐ or NO☐

Name(s) and location(s) of any witnesses:

_____

_____

_____

Was medical attention required? YES or NO. If Yes, name and address of medical provider:

_____

_____

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Employee Statement of how accident or exposure occurred; describe fully what happened, how it happened, body part(s) affected, and equipment or material in use at the time; use back of form if necessary.

_____

_____

_____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Supervisor statement:

_____

_____

_____

_____

Supervisor's Signature: _____ **Date:**_____

Witness [s] statement of how injury/illness occurred (if available):

_____

_____

_____

_____

_____

Witness Signature _____Date_____

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