RESOURCE CENTER FOR INDEPENDENT LIVING, INC.
ACCIDENT REPORT
(Employee/Injured individual please complete this section)

- Employee/Injured individual must **report** any accident to their supervisor and the Human Resources department **immediately.**
- Employee/Injured individual must complete this form and ask any witnesses or supervisors to complete their section as well. This must be completed within **24 hours** of the accident. Please submit by e-mail to dnasso@rcil.com, by fax to (315) 272-2954, or by **mail** to:

RCIL
c/o Human Resources
409 Columbia Street
PO Box 210
Utica, NY 13503-0210

Name: ____
Last First MI

____
Address/Street Town/City State Zip Code

Phone #:__________________ Circle one: Male Female Date of Birth:____________

SS#: ___________________ DOH: ________________________

Coordinator: __________________ Direct line: _________________ E-mail: _____________________

Information on Accident/Occurrence:

Date of Accident: ______________________ Time:______________ (a.m./p.m.)
Month/Day/Year

Location of accident (address):____

Employee's Work Schedule:
Days per week: ________________________ Rate of pay:_____________________
Hours per day:_________________________ Title:___________________________
Program Name: ________________________ Time began work: ____________ (a.m./ p.m.)

Full Time / Part Time. (circle one)

Consumer Information (if applicable):

Name: ________________________ Phone #: _____________________

Employee's Injury Description:

What was the employee doing just before the incident occurred?___________________________

____

Describe injury:____

____

What happened? (explain how injury occurred)____

____

What object or substance directly harmed the employee, if any? _________________________

Employee's Medical Attention:

What actions resulted from the accident (First Aid given)? Was there a follow up with a Physician or Hospital:

____

____

Physician/Provider: ____
Name Phone

____
Address

Hospital/Urgent Care: ____
Name Phone

____
Address

Was employee taken by ambulance? _______Yes _______ No

Was employee hospitalized overnight as an in-patient? _______Yes _______ No

Did the employee return to work on that day? _______Yes _______ No

Did the physician release the employee to work? _______Yes _______ No

Date employee was able to return to work: _______________________________

Was light duty discussed as an option? _______Yes _______ No

Were there any witnesses to the accident: _______Yes _______ No

Do you question the validity of this claim? _______Yes _______ No

Name(s) and phone number(s) of witness(es):

____

If yes, have the witness(es) complete the attached Witness Form.

Completed by ________________________________ **Title** _______________________
(Signature)

Phone _____________________________ **Date** _______________________

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ACCIDENT REPORT
WITNESS PORTION

Name of Employee/Injured Individual: ____

Date of Accident: ____

Name of Witness: ____

Address of Witness: ____

Phone # of Witness: ____

1) Witness description of accident (include cause, if known, and description of what happened):

____

____

____

____

2) Address /Location of Accident: ____

____

3) Were there any other witnesses: ______Yes ______ No

If ***Yes***, provide name(s) and phone number(s) if possible:

____

____

_________________________________ ______________________________

Witness Signature **Date**

RESOURCE CENTER FOR INDEPENDENT LIVING, INC.
ACCIDENT REPORT
SUPERVISOR/COORDINATOR PORTION

Employee Name: ____

____
Location Address/Street   Town/City   State   Zip Code

Date of Report: ___________ Date of Injury: _______________ Time of Injury:___________

Length of Job: ___________ Date Hired: _________________

Supervisor/Coordinator's account of injury/injury site: ________________________________

____

Location of Injury (please be specific): ____

Please describe in detail what happened: ____

____

____

____

Specifically what caused the accident: ____

____

Are there preexisting injuries: ____

Do you question the validity of this claim?: ____

Did the employee receive medical treatment: ______Yes ______ No

If ***"Yes"*** where: ____

If ***"Yes"*** how did the employee get there: ____

_________________________________ _____________________________
Supervisor Signature **Date**

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ACCIDENT REPORT
CONSUMER/PARTICIPANT INFORMATION

Name: ____

____
Location Address/Street Town/City State Zip Code

Date of Injury: _______________ Time of Injury:_______________

Date Hired: _______________

Job Duties/ Occupation: ____

____

Any personnel issues? Yes ______ No _______

If yes, describe: ____

Is there equipment available to use if lifting is involved? Yes ______ No _______

If yes, what type? ____

Details of any known work restrictions: ____

____

Can restrictions be accommodated? Yes ______ No _______

If yes, for how long? ______________________________________

If yes, what restrictions can be accommodated? (e.g. lifting or sitting restrictions)

____

Are there preexisting injuries: ____

Only complete below if accident/injury was incurred due to a motor vehicle accident:

Vehicle Type (please be specific): ____

Location of Accident (please be specific): ____

Was a police report filed: ______Yes ______ No

Who is the auto insurance carrier: ____