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 **within 24 hours** of the accident
- Employee/Injured individual must complete this form and ask any witnesses or supervisors to complete their section as well. **Mail** all sections to:

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

Name: _____
Last First MI

_____
Adress/Street Town/City State Zip Code

Phone #:_____ 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:_____
Full Time:_____ Part Time: _____ Time began work: _____

Consumer Information (if applicable):

Name: _____ Phone #: _____

Describe injury:_____

_____

_____

What were you doing at the time of the accident? How did it occur?_____

_____

Was there an object involved? If yes, what? _____

What actions resulted from the accident? Was there a follow up with a Physician or Hospital:

_____

_____

Physician: _____
Name Phone

_____
Address

Hospital/Urgent Care: _____
Name Phone

_____
Address

Did you return to work on that day? _____Yes _____ No

Did the physician release you from work? _____Yes _____ No

Date you are able to return to work: _____

Was lite duty discussed as an option? _____Yes _____ No

Were there any witnesses to the accident: _____Yes _____ No

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

_____

_____

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

_____ _____

Signature of Employee/Injured Individual **Date**