**Resource Center for Independent Living, Inc.**

**Accident Report Form (CDPAP, Self Direction)**

*To Be Completed by the Injured Worker*

Injured Workers must report any Accident to their Supervisor **and** RCIL’s Human Resources Department **immediately**. This Accident Report Form must be completed by the Injured Worker and submitted to RCIL’s leave management broker, Crown Risk Management, LLC via one of the following methods:

1. **Email:** jgwynn@crownrisk.com
2. **Fax:** (315) 428-3829
3. **Mail:** Crown Risk Management, LLC Attn: Jessica Gwynn; 432 North Franklin Street, Suite 20; Syracuse, NY 13204

**Your Information:**

|  |  |
| --- | --- |
| Last Name: |  |
| First Name: |  |
| Middle Name: |  |
| Address: |  |
| Phone Number: |  |
| Email Address: |  |
| Date of Birth: |  |
| Gender: |  |
| SS Number: |  |
| Date of Hire: |  |

**Program Information:**

|  |  |
| --- | --- |
| Consumer/Participant Name: |  |
| Phone Number: |  |
| Address: |  |
| **Consumer Designated Representative / Participant Designee Information: (if applicable)** |
| Name: |  |
| Phone Number: |  |
| Address: |  |

**Information on Accident/Injury/Illness:**

|  |  |
| --- | --- |
| Date of Accident: (MM/DD/YY) | Time of Accident: [ ]  AM [ ]  PM |
| Location of Injury/Illness (Address): |
| What were you doing when the Incident or Injury occurred? |
| Explain how the Injury occurred? |
| List all body parts injured: |
| Did you give notice of your Injury/Illness to your Supervisor or RCIL? [ ]  YES [ ]  NO |
| If YES, list name(s) of individual(s) notified, date you provided notice and whether you provided notice in writing or verbally: |
| Individual: | Date Notified: | Manner Notified: |
| Individual: | Date Notified: | Manner Notified: |
| Individual: | Date Notified: | Manner Notified: |

**Medical Treatment Received:**

|  |  |
| --- | --- |
| Date of first medical treatment received: |  |
| Location of initial medical treatment received: (specify below) |
| Initial Hospital/Urgent Care Name and Address: |  |
| Were you taken by Ambulance? | [ ]  YES [ ]  NO |
| If YES, name of Ambulance Company: |  |
| Initial Physician/Provider Name and Address: |  |
| Are you still receiving medical treatment for your injury/illness? | [ ]  YES [ ]  NO |
| If YES, provide the names and addresses of doctors you are treating with: (specify below) |
| Physician/Provider Name and Address: |  |
| Physician/Provider Name and Address: |  |
| Physician/Provider Name and Address: |  |

**Witnesses:**

|  |  |
| --- | --- |
| Were there any Witnesses to the Accident: | [ ]  YES [ ]  NO |
| If YES, identify all Witness(es) below: |
| Witness Name and Phone Number: |  |
| Witness Name and Phone Number: |  |
| Witness Name and Phone Number: |  |

**Employment Status:**

|  |  |
| --- | --- |
| Are you currently working for RCIL in your regular pre-injury position? | [ ]  YES [ ]  NO |
| Are your currently working for RCIL in a lighter duty position by reason of work restrictions due to this Injury/Illness? | [ ]  YES [ ]  NO |
| If YES, please list restrictions: |
| Have you contacted RCIL about working light duty? | [ ]  YES [ ]  NO |
| If YES, who did you contact at RCIL about working light duty? |
| Since your date of Injury/Illness, have you performed any work or services (including self-employment and volunteer work) for any employer, person, or yourself in exchange for cash, check, goods, or services?  | [ ]  YES [ ]  NOIf YES, for whom: |

**Past Medical History:**

|  |
| --- |
| Have you ever had any prior symptoms, injuries, or medical treatment for any of the body parts injured?[ ]  YES [ ]  NO |
| If YES, list all body parts with prior symptoms, injuries or medical treatment and the names/addresses of the doctor(s) who treated you: |
| Body Part: | Doctor/Hospital: |
| Body Part: | Doctor/Hospital: |
| Body Part: | Doctor/Hospital: |

**Attestation:**

|  |
| --- |
| I am hereby making a claim for a work-related injury and benefits under the NYS Workers Compensation Law. In signing below, I affirm under the penalties of perjury all the information provided above, whether completed by myself or another, is based on my representations and are true and accurate to the best of my knowledge and belief. |
| **Completed By (Print Name):** |
| **Signature:** |
| **Date:** |