EMPLOYEE'S REPORT OF ACCIDENT/INJURY

Submit this form to your supervisor.
Read and answer all questions fully. This is your notice to your employer of an accident/injury on the job.
Print or write legibly. Failure to submit this claim in a timely manner may result in a denial of your claim.

Full Name of Injured Person:

(First) **(Middle)** **(Last)**

Address (Number, Street Name and Apt#):

(City) **(State)** **(Zip Code)**

Home Telephone No. ( )	**Cell Telephone No.** ( )	**Work Telephone No.** ( )

Employee's Date of Birth: (Month) (Day) (Year)	**Employee's Personal Email Address:**

Name of Employer (New York City Health + Hospitals) of:

Department Name:	**Title**:
Date of Accident: **(Month)** **(Day)** **(Year)**	**Time of Accident:** **(Hour)** **AM** **PM**

Exact location where accident happened:____
____

How did accident happen? (Describe fully)
____
____

Nature and extent of injury:____
____
____

Did you inform your supervisor of this accident? **Yes** **No**	**If yes, what was the date?**

Name of supervisor:

Name, telephone no. and addresses of witnesses:____
____
____

Dated: **(Month)** **(Day)** **(Year)**	**Signature:**

THIS IS NOT A CLAIM FORM. A CLAIM FORM MAY BE SECURED AT ANY OFFICE OF THE STATE WORKER' COMPENSATION BOARD.