NEW YORK CITY
HEALTH AND HOSPITALS
CORPORATION

SUPERVISOR'S REPORT OF OCCUPATIONAL ACCIDENT/INJURY

RESULT (To be completed by Personnel Department)

☐ NO INJURY Hazardous Situation	☐ INJURY No. W.C.B. Claim ☐ FIRST AID	W.C.B. CLAIM ☐ Medical Aid ☐ Lost Time

A. ASSIGNED WORK LOCATION OF WORKER

FACILITY	FACILITY CODE	DEPARTMENT	UNIT

B. EMPLOYEE IDENTIFICATION

Last Name	First Name	Sex	Area Code / Phone Number	Date of Birth (Month / Day / Year)
		1 ☐ Male 2 ☐ Female	( )	

Address (no., street, apt.)	City/Town	State	Zip Code	Language spoken if not English

Date of Employment (Month / Day / Year)	HHC Job Title at time of the injury and years in current title	Title Code Number	Social Security No.
	Years		

C. NON-HHC EMPLOYEE CATEGORY

If worker is NOT an HHC employee, check appropriate status:

1. ☐ Affiliate Employee
2. ☐ Medical Student
3. ☐ Nursing Student
4. ☐ Other Student
5. ☐ NRI/Temporary
6. ☐ Volunteer
7. ☐ Other (specify): _____

D. DATE, TIME AND LOCATION OF ACCIDENT/INJURY

1. Month/Day/Year of occurrence	2. Time of occurrence (approx. if exact time unknown)	3. Date occurrence reported month / day / year	4. Shift occurred	5. How many continuous hours worker on duty prior to this occurrence?
/ /	: ☐ AM ☐ PM	/ /	☐ Day ☐ Evening ☐ Night	

6. Building	7. Floor	8. Wing	9. Room No./Name	10. Area (hallway, utility closet, etc.)	11. ☐ EMS Vehicle 12. ☐ Patient's Residence

E. DUTY STATUS

1. ☐ On-Duty
2. ☐ Off-Duty

F. OCCURRENCE CATEGORIES

Definitions on reverse

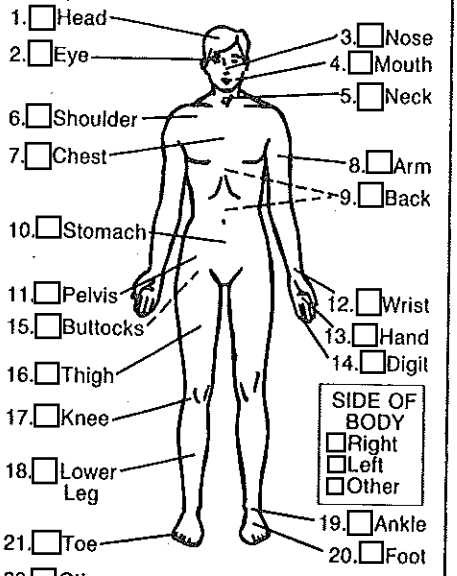
1. ☐ Struck by or contact with
2. ☐ Caught in, on or between
3. ☐ Slip, trip or fall
4. ☐ Patient/visitor action
5. ☐ Exposure
6. ☐ Needlestick/Body Fluid exposure (Complete Needlestick form HHC 1635)
7. ☐ Lifting, carrying, pushing or pulling
8. ☐ Repetitive motion
9. ☐ Other

G. CATEGORIES OF HAZARDOUS SUBSTANCES, PROCESSES OR CONDITIONS

Examples of categories on reverse — *Indicate name or type:*

1. ☐ Mechanical equipment, tools, VDT's: _____
2. ☐ Physical Hazard(s): _____
3. ☐ Material Handling: _____
4. ☐ Patient/Visitor Handling: _____
5. ☐ Patient Care Related Equipment and Devices: _____
6. ☐ Chemical(s): _____
   a. ☐ Solid b. ☐ Liquid c. ☐ Gas
   d. ☐ Vapor/Mist e. ☐ Particulates
7. ☐ Metal(s): _____
   a. ☐ Solid b. ☐ Liquid c. ☐ Fumes
8. ☐ Radiation: _____
   a. ☐ Ionizing (e.g. x-ray) b. ☐ Non-Ionizing (e.g. UV)
9. ☐ Noise (db level if known): _____
   a. ☐ High Frequency b. ☐ Low Frequency
10. ☐ Other: _____

H. BODY PART(S) INJURED OR EXPOSED (Check all that apply)



COPY: EHS

I. DESCRIPTION

STATE EXACTLY – WHAT WAS THE SEQUENCE OF EVENTS LEADING UP TO THE OCCURRENCE, WHERE IT OCCURRED, WHAT EMPLOYEE WAS DOING, SIZE, WEIGHT AND TYPE OF EQUIPMENT OR MATERIALS INVOLVED, ETC.

J. WITNESS (If witness is a worker, list Department, Unit and work telephone number)

NAMES, ADDRESSES AND PHONE NUMBERS OF WITNESSES TO THE OCCURRENCE:

K. RECOMMENDATIONS TO PREVENT REOCCURRENCES

L. INFORMATION ABOUT SUPERVISOR MAKING REPORT

Name: _____ _____
Print *Signature*

Title: _____ Work Phone: (_____) _____–_____

Date of Report: _____/_____/_____
month day year

M. MEDICAL DISPOSITION (To be completed by the EHS or the ER if applicable).

INJURED WORKER EXAMINED IN: 1.☐ EHS 2.☐ ER 3.☐ Other (specify):_____

If worker was not seen by the EHS or ER, please indicate why not: _____

STATEMENT OF MEDICAL FINDINGS/DIAGNOSIS: _____

DISPOSITION: 1.☐ Returned to duty 2.☐ Unable to return to duty Date of examination: _____/_____/_____
month day year

Name of examining physician: _____ _____
Print *Signature*