BUFFALO STATE
The State University of New York

Accident Report
ARS# 1-888-800-0029

Instructions: Complete Part 1 and Part 3. Provide Part 2 to your supervisor to complete. Forward to Human Resource Management for Processing. You must report the injury to the Accident Reporting System (ARS) 1-800-800-0029.

Name:		ARS#:	Date of Accident:
Department:		Primary Contact Phone Number:	
Home Address:			Please Check One: ☐ CSEA ☐ PEF ☐ UUP ☐ MC ☐ NYSCOPBA ☐ PBANYS
Location of Occurrence and Description:			
Time of Accident: ☐AM ☐PM	Time Shift Began: ☐AM ☐PM	Did you remain on duty the rest of your shift? ☐YES ☐NO	
Date of Report:	Was this the result of a motor vehicle accident? ☐YES ☐NO	Was the injury a result of an assault or restraint? ☐YES ☐NO	
Pass Days: ☐Sun ☐Mon ☐Tue ☐Wed ☐Thur ☐Fri ☐Sat		Job Title:	
First person you told of accident:		Provide name(s) of any witness(es):	

Describe in detail your injury and what you were doing when the injury/illness occurred:

What tools, equipment, objects or substances were involved?

Medical Information: **Was Medical Assistance Rendered?** ☐ No ☐ Yes

When was treatment performed?	Did you do to the hospital? ☐ No ☐ Yes Did you seek first aid by
Treating Healthcare Provider Information: Name, Address and Phone Number Name, Address and Phone Number	

Part 2: To be completed by your direct supervisor. If form is not completed by direct supervisor, please indicate the name and title of who is completing the form and provide the name and title of your direct supervisor. This form must be turned in immediately.

Name of Person Completing Section: Title:

Supervisor Name: Supervisor Title:	Date and time you were notified of injury/illness
Did employee continue working? ☐ No ☐ Yes If No, date left work:	First full date of absence: Date employee returned:

Supervisor Comments:

Supervisor Signature: Date:

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Part 3: You must complete Part 3 and sign at the bottom of the page. Please check all that apply with respect to your injury/illness. You should have at least one box checked in each column.

Body Part(s)	Nature of Injury/Illness	Event(s)/Cause(s)	Source(s)/Exposure(s)
☐ Abdomen	☐ Abrasions/scrapes/scratch	☐ Alleged Assault	☐ Animal
☐ Ankle ☐ Left ☐ Right	☐ Allergic Reaction	☐ Alleged Harassment	☐ Bacteria/Virus/Fungus
☐ Arm ☐ Left ☐ Right	☐ Bite(s)/Sting(s)	☐ Bending/Stooping	☐ Bed/Stand
☐ Back, Inc Spine	☐ Breathing Difficulty	☐ Climbing	☐ Blood/Body Fluids
☐ Body Systems	☐ Burn(s)	☐ Collapse	☐ Body Movement/Motion
☐ Breast ☐ Left ☐ Right	☐ Chest Pain	☐ Collided with	☐ Broken Glass/ Sharp Object
☐ Buttock(s)	☐ Head Injury	☐ Computer Use	☐ Buildings and Premises
☐ Chest	☐ Contusion(s)/Bruise(s)	☐ Construction	☐ Carts/Dollies
☐ Ear ☒ Left ☐ Right	☐ Crush Injury	☐ Contact with	☐ Chemical(s) Specify:_____
☐ Elbow ☐ Left ☐ Right	☐ Repetitive Strain/Sprain	☐ Fall	☐ Cleaning Agent Specify:_____
☐ Eye ☐ Left ☐ Right	☐ Death	☐ Grounds work	☐ Computer
☐ Face	☐ Dislocation(s)	☐ Housekeeping	☐ Co Worker
☐ Finger(s) ☐ Left ☐ Right	☐ Dizziness	☐ Ingestion	☐ Dust/Airborne Particles
☐ Foot ☐ Left ☐ Right	☐ Electric Shock	☐ Inhalation	☐ Electricity
☐ Groin	☐ Exposure(s)	☐ Kneeling	☐ Elevator
☐ Hand ☐ Left ☐ Right	☐ Foreign Body	☐ Lifting	☐ Equipment Specify:_____
☐ Head	☐ Broken Bone	☐ Material Handling	☐ Explosion and/or Fire
☐ Hip ☐ Left ☐ Right	☐ Headache	☐ Needle Stick	☐ Falling Object(s)
☐ Internal Organ(s)	☐ Hearing Disorder/loss	☐ Overexertion	☐ Floor
☐ Knee ☐ Left ☐ Right	☐ Hernia	☐ Overextension	☐ Friction
☐ Leg ☐ Left ☐ Right	☐ Infectious/Parasitic Disease	☐ Pinched	☐ Fume(s)/Noxious Odor(s)
☐ Lip(s)	☐ Internal Organ Injury	☐ Pulling	☐ Gas(es)
☐ Lung ☐ Left ☐ Right	☐ Laceration(s)/Cut(s)	☐ Pushing	☐ Ground
☐ Mouth	☐ Loss of Consciousness	☐ Reaching	☐ Hand Tool(s)
☐ Neck	☐ Mental Disorder/Stress/Anxiety	☐ Repetitive Work	☐ Hot or Cold Temperature
☐ Nose ☐ Left ☐ Right	☐ Muscle/Tendon/Ligament/Joint/Inj	☐ Restraining Person	☐ Insect(s)
☐ Pelvis	☐ Nausea/Vomiting	☐ Slip/Trip/Loss of Bal w/o Fall	☐ Instrument(s)
☐ Ribs ☐ Left ☐ Right	☐ No Apparent Injury	☐ Spill	☐ Lighting
☐ Shoulder ☐ Left ☐ Right	☐ Numbness/Tingling	☐ Spray/Splash	☐ Loud Noise
☐ Skin	☐ Pain	☐ Struck Against	☐ Motor Vehicle
☐ Stomach	☐ Paralysis/Weakness	☐ Struck By	☐ Office Equipment
☐ Tailbone	☐ Poisoning	Other - List:	☐ Organic Compounds
☐ Teeth	☐ Puncture(s)		☐ Paints/Solvents
☐ Thigh ☐ Left ☐ Right	☐ Resp. Distress/ Shortness of Breath		☐ Parking Garage
☐ Thumb ☐ Left ☐ Right	☐ Splinter(s)		☐ Parking Lot
☐ Toe(s) ☐ Left ☐ Right	☐ Sprain(s)/Strain(s)		☐ Radiation
☐ Tongue	☐ Swelling		☐ Scaffold
☐ Wrist ☐ Left ☐ Right	☐ Visual Disturbance(s)		☐ Sharp Object Specify:
Other – List:			☐ Sidewalk/Curb/Pavement
			☐ Snow/Ice
			☐ Stairwell
			☐ Steam
			☐ Student
			☐ Vibration
			☐ Visitor
			☐ Volunteer
			☐ Water/Liquid
			☐ Window/Door

Signature Of Injured Person: _____

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Essential Responsibilities for Workers Compensation Injuries/Illnesses

Employee

If you have an accident while at work, you should know the proper steps to be taken to ensure your workers' compensation benefits

1. Information on this report must be forwarded to the Office of Human Resources immediately following an on-the-job accident or injury. This document is required under NYS PEHS Rule Part 801.
2. The employee must report the Injury/Illness to ***1-888-800-0029*** within 24 hours of the incident. The NYS Accident Reporting System (ARS) electronically assigns numbers to the claim for easier processing. This is also called the incident number.
3. Inform your supervisor and/or Human Resources of Injury/Illness date and any lost time or medical treatment related to the injury current or at a future date. If medical care is provided at a later date, the employee will need to call the ARS again to report medical.
4. The employee must complete **Part 1 and Part 3** of the Accident Report with as much information as possible regarding the injury or illness (include the ARS # on the form). Details are important.
5. The form must be signed by the employee and their supervisor. If the form is not completed by the direct supervisor, please indicate the appropriate information of who is completing the form in Part 2. This form must be turned in immediately.
6. If the employee cannot complete the initial form, due to injury, the supervisor or representative needs to complete and submit to HR. The employee will also need to complete their own form, when able.
7. The form must be submitted to Human Resources to get the claim started. Information will be sent to the employee's home address from NYSIF, therefore it is very important that the complete home address and telephone number, including area code be provided.
8. **DO NOT FILE CLAIMS UNDER YOUR NYS HEALTH INSURANCE.** Employees must notify their physician that this is work related and any bills need to be sent to NYSIF (State Insurance Fund). **NYSIF 100 Chestnut St, Suite 1000, Rochester, NY 14604.** Policy # 240960
9. **If you require medical attention, you must provide a statement from your treating physician indicating a diagnosis, the date you were seen and a return-to-work date.** If your treating physician is recommending a return to work with restrictions, please contact Human Resource Management.
10. RTW documentation must be sent to Human Resources 48 hours prior to the date for review/approval.
11. If you are out due to a work-related injury, the first 5 days are charged to your accruals. If you are out more than 5 days, you will be provided with information from Human Resources.

Supervisor(s)

1. The injured employee's supervisor is responsible for notifying the Office of Human Resources of the exact dates the employee is absent from work due to the accident or injury. Any subsequent time due to the injury must be reported to the Office of Human Resources.
2. The supervisor must complete PART 2 of the Injury/Illness report and verify that the form is completed in full, including signatures.
3. Keep Human Resources informed of any correspondence with the employee and confirm with Human Resources when the employee intends to return to work.

Fraud Statement of Workers' Compensation:

Any person who knowingly with intent to defraud makes a materially false statement or conceals a material fact to obtain a benefit shall be guilty of a crime and subject to fines and imprisonment. Reports suspected of workers' compensation fraud will be sent to the Workers' Compensation Faud Inspector General Office, 518-473-4839, or Workers' Compensation Fraud, Inspection General, New York State Workers' Compensation Board 100 Broadway-Menands, Albany, New York 12241.

The above information is published by the Employee Benefits Division of the state of New York, Department of Civil Service, the NY State Insurance Fund, and the Workers' Compensation Board.