

Broome County Office of Risk & Insurance Management

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WORKERS' COMPENSATION ACCIDENT REPORT

Answer all questions fully. Attach additional sheets as needed.

Employee Name: _____ SSN: _____

Date of accident: _____ Approximate time: _____ Hour began work _____

Department Employed by (i.e. dept, municipality, etc): _____

Where did the accident happen? _____

What job duty were you performing when you were hurt? _____

Describe in detail how you were injured: _____

Body Part Injured (Specify Left or Right): _____

Type of Injury (i.e. bruise, cut, break, etc): _____

Please list witness's to the accident: _____

Were you wearing required Protective Equipment? (e.g. safety glasses, gloves, etc.) Yes No

Did you go to the Emergency Room? Yes No If yes, provide:

Hospital: _____ Were you hospitalized overnight? Yes No

Did you see another doctor? Yes No If yes, provide:

Physician name and address: _____

It is a crime punishable as a Class A Misdemeanor under the laws of the State of New York for a person in and by a written instrument to knowingly make a false statement or to make a statement which such person does not believe to be true.



Employee Signature

Date Completed

To be completed by Supervisor

Date Supervisor notified: _____ Supervisor's Name (print): _____

Was employee following proper procedure and wearing appropriate PPE? Yes No

If no, please explain: _____

I agree/disagree (circle one) with the employee's statement _____

Supervisor Signature and Date