OPRHP INJURY AND ILLNESS REPORT

Volunteer Information

|  |  |
| --- | --- |
| NAME: | PARK: |
| SS#: XX-XXX-\_\_\_\_\_\_ |  |
| ADDRESS: |  |
|  |  |
| DATE OF BIRTH: | MALE FEMALE |
| Phone #: **Circle normal days worked: M Tu W Th F Sa Su** | |
|  | |
| Injury Information | |
| DATE OF ACCIDENT: | TIME OF ACCIDENT: AM PM |
| TIME EMPLOYEE **BEGAN WORK** THE DAY OF INCIDENT: AM PM | |
|  | |
| STATEMENT OF EMPLOYEE INJURY: *be specific – what, where, when, how, body part injured, etc.* | |
|  | |
|  | |
|  | |
|  | |

Medical Information Lost Time Information

|  |  |  |
| --- | --- | --- |
| ***(Complete only if medical attention was received)*** | |  |
| NAME OF PHYSICIAN: | | LOST TIME INVOLVED: YES NO |
| DOCTOR/HOSPITAL ADDRESS: | | IF YES, LAST DATE WORKED: |
|  | |  |
| WAS EMPLOYEE TREATED IN THE ER? | | 1ST FULL DAY OF ABSENCE: |
| WAS EMPLOYEE TAKEN TO ER VIA AMBULANCE? | |  |
| WAS EMPLOYEE HOSPITALIZED OVERNIGHT? | | RETURN TO WORK DATE: |
|  | | |
|  | | |
| To be completed by Supervisor To be completed by Employee | | |
| **DATE INFORMED OF INJURY:** | **SIGNATURE:** | |
| **SIGNATURE:** | **DATE:** | |
| **DATE COMPLETED :** |  | |
| **TITLE:** |  | |
| **PHONE#:** |  | |
| **COMMENTS:** | | |
| **\*\*PLEASE FAX COMPLETED FORM TO PERSONNEL @ 518-486-1950\*\*** | | |

**PERSONNEL OFFICE USE ONLY:**

|  |  |  |
| --- | --- | --- |
| **PESH** | **C-2 DONE**  **DATE** | **OTHER:** |

***FORM REVISED 10/04/17***