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***