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

(Complete only if medical attention was received)
NAME OF PHYSICIAN:
DOCTOR/HOSPITAL ADDRESS:

WAS EMPLOYEE TREATED IN THE ER?
WAS EMPLOYEE TAKEN TO ER VIA AMBULANCE?
WAS EMPLOYEE HOSPITALIZED OVERNIGHT?

Lost Time Information

LOST TIME INVOLVED: YES ☐ NO ☐
IF YES, LAST DATE WORKED:

1ST FULL DAY OF ABSENCE:

RETURN TO WORK DATE:

To be completed by Supervisor

DATE INFORMED OF INJURY:
SIGNATURE:
DATE COMPLETED :
TITLE:
PHONE#:

To be completed by Employee

SIGNATURE:
DATE:

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