RESEARCH FOUNDATION CUNY

RESEARCH FOUNDATION
of The City University of New York
230 West 41st Street
New York, NY 10036-7207

EMPLOYEE'S NOTICE OF INJURY

Submission of this form and a copy of the employee's job description serve as notice to the Research Foundation of the employee's work-related injury. Please answer all questions as fully as possible, print and sign the form at the bottom, and forward all documentation to the Department of Human Resources.

Personal Information

Name_______________ Employee ID No. _______________

Address_______________Apt_______________

City_______________State_______________Zip Code_______________

Home Phone (______) _________- _______________ Work Phone (______) _________- _______________

Male Female Date of Birth _______ - _______ - _______ Marital Status _______________

Job Information

Campus _______________Work Location/Address _______________

Employment Status FT PT Job Title _______________
(Must include copy of Job Description)

Time Works Begins _______________ Time Work Ends _______________ Work Days_______________ Work Hours_______________

Supervisor's Name _______________ Contact # (______) _________ -

Witness Information

Name _______________

Address _______________

Telephone (____) _________ - _______________ List additional witnesses in comments section. _______________

Injury Information

Date of Injury_______________ Time of Injury_______________AM PM

Exact Location of Injury_______________

Describe how the accident occurred in detail including nature of injury and part of body injured ______________________

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Equipment, Material or Substances Involved ______________________

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Medical Information

Prior Injury or Pre-existing Conditions ______________________

Did you receive medical attention? Yes No If yes, please describe ______________________

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Health Care Provider's Name, Address and Contact # ______________________

______________________ Telephone (______)________- ______________________

Was an ambulance used to transport you to a hospital? Yes No If yes, give Hospital Name and Address __________

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Name and Telephone of Attending Physician ______________________ Telephone (________)________- ____________

Work Attendance

Date you last worked ______________________ Date you returned to work ______________________

Dates of absence as a result of this Injury ______________________

Additional Comments or Additional Witness Information ______________________

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Employee's Signature ______________________ Date ______________________