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 _____ Phone _____

Witness Information

Name _____

Address _____

Phone _____

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.

Equipment, Material or Substances Involved

Medical Information

Prior Injury or Pre-existing Conditions

Did you receive medical attention? Yes ☐ No ☐

If yes, please describe

Health Care Provider's Name

Health Care Provider's Address

Health Care Provider's Phone

Was an ambulance used to transport you to a hospital? Yes ☐ No ☐

If yes, give Hospital Name and Address

Name of Attending Physician

Phone of Attending Physician

Work Attendance

Date you last worked Date you returned to work

Dates of absence as a result of this Injury: From To

Additional Comments or Additional Witness Information

Employee's Signature Date