Syracuse University
Workers' Compensation Reporting Form

Please return completed form to Risk Management 119 Euclid Ave Syracuse NY 13244 or via email to SLBuck01@syr.edu or fax 315-443-1154

Injured Worker Information:

Name: _____

SUID: _____ **Department:** _____

Date of Birth: _____

Home Address: _____

Phone: _____

Date and time of incident: _____ **Time started work:** _____

Description of incident: Please be detailed and include where you were, what you were doing, how the accident happened and body parts:

_____

_____

_____

_____

Signature/Date _____

Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which is a felony

Supervisor Statement:

Your description of the incident based on discussion with worker:

_____

_____

Contributing factors: Ex: Weather/Machinery or unsafe practices:

_____

Blood or body fluids contact: Who: _____

Lost time: RTW? _____

Medical Treatment: Where: When: _____

Witness: _____

Supervisor's Signature/Date: _____

Additional space on reverse of form if needed, for either employee or supervisor use

Additional Comments: be sure to be clear about WHO is commenting!

If you have and questions or concerns, please contact:

Sheera Buckley in Risk Management: 315-443-5106/SLBuck01@syr.edu