Broome County Office of Risk Management
Broome County Office Building . 60 Hawley Street
P.O. Box 1766, Binghamton, NY 13902 www.gobroomecounty.com
Main Office: Phone (607)778-2402 Fax: (607)778-2918

Incident Only Reporting Instructions
Effective March 6, 2014

BLUE PACKET

1. **To be used only for reporting of an incident with no lost time from work or medical treatment.**

2. **WC Form 1 Claimant's Statement** – to be completed and signed by claimant.

3. **WC Form 2 Supervisor's Statement** – to be completed and signed by Supervisor and provided to the Department Head for signature.

4. **WC Form 3 Witness Statement** – to be completed by any and all witnesses of the reported accident/incident. Each witness must complete a separate statement.

5. **If lost time or treatment occurs after filing this incident report, a full workers' compensation packet (Pink Packet) must be completed within 5 days of treatment or 1st day of lost time.**

For quicker notifications, the packet can be faxed to (607) 778-2918 or emailed to bcworkerscomp@co.broome.ny.us, but all originals must be forwarded to Risk & Insurance via interoffice mail or through standard mail

I have read the above instructions and understand that it is my obligation to notify my supervisor or department if I go for treatment or lose any time from work due to this incident. I also understand that if lost time or treatment occurs due to this incident, I must complete the full Broome County Workers' Compensation Packet.

Signature of employee (claimant) **Date Signed**

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CLAIMANT'S STATEMENT

Person Injured ______________________________ Social Security# ________________
(Last Name) (First Name) (Initial)

Date of Birth ____________ Date of Hire ____________ Job Title ______________________

Home Address ____

Phone Number ____________________ Department Employed By ____________________

Date of Incident ____________ Hour began work ______ AM PM Time of Injury ______ AM PM

Exact Location of Incident ______________________ Medical Treatment: ☐ Yes ☐ No

Property/Equipment Involved ____

Describe exactly what happened (attach additional pages if necessary) ____________________

____

____

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____

Body Part injured (Be specific to right or left) ________________________________

Witnesses to Incident Witness Department Witness Contact information

____

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Attach additional pages if needed

Illness Cases Only ☐ Check this box if the employee independently and voluntarily requests that his or her name not be entered on the log. If checked, treat as a privacy concern case

My signature affirms and certifies that the information I have provided is true and accurate, that no false statements or representations or material omissions have been made in support of any claim for payment, and that I understand that that this document will be presented to an insurer and become a part of the records of Broome County.

______________________________________ ____________________

Signature and title of person preparing report **Date**

SUPERVISOR/DEPARTMENT HEAD STATEMENT
Please attach additional pages, if necessary

Injured Employee's Name ______________________ Supervisors name ______________________

Date notified of Injury ______________________ Time notified ______________ AM PM ______________

Did you witness the Accident/Injury? ☐ Yes ☐ No

If yes, please describe the incident/accident in detail as witnessed along with employee's condition after injury _______

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If No, please state the claimant's account of the injury and your observation of their condition at the time of reporting (i.e limping, cut, bruised, etc)

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Do you agree with the claimant's statement of injury? ☐ Yes ☐ No

If you do not agree with the statement of injury, please explain: ______________________________

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Was Personal Protective Equipment required ☐ Yes ☐ No If Yes, was it used properly ☐ Yes ☐ No

Please list any unsafe conditions or hazards that caused/contributed to this incident ______________

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Please note any precautions that should be taken to prevent a similar injury in the future ______________

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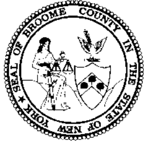
SIGNATURE OF SUPERVISOR **DATE**

____

SIGNATURE OF DEPARTMENT HEAD **DATE**



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WITNESS STATEMENT

(Each witness must complete a separate statement)

Attach additional pages, if necessary

Injured Employee's Name ____

Date of Accident/Incident ____________________ Time of Incident______________ AM PM

Location of Incident ____

Witness Name______________________________ Witness Job Title_____________________

Witness Department_________________________ Witness Phone Number________________

Witness Description of Incident (Include as much detail as possible): ______________________
(attach an additional page if necessary)

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My signature affirms and certifies that the information I have provided is true and accurate, that no false statements or representations or material omissions have been made in support of any claim for payment, and that I understand that this document will be presented to an insurer and become a part of the records of Broome County.

_____________________________________ _____________________

Witness Signature Date Signed