Town of Long Lake, NY
Accident/Incident/Near-Miss Report

INSTRUCTIONS **Complete all sections of form within 24 hours of the accident/incident/near-miss.** **Return to Workers' Compensation (WC) Administrator at the Town Offices.**

EMPLOYEE INFORMATION						
Today's Date:	Date of Incident:			Time of Incident:		
Employee's Name:			Date of Birth:	Social Security #:		
Home Address:				Phone #:		
Job Title:				Date of Hire:		
Employment Status:	Full-Time	Part-Time	Elected	Seasonal	# Days work in a week:	
Have you notified your Supervisor of the accident/injury?	YES	NO	Name of Supervisor:			
Did you leave work due to the injury?	YES	NO	Did you seek medical care?	YES, where?	NO	
Person completing report if other than above:						
List Witnesses to Accident/Incident:						

ACCIDENT/INCIDENT INFORMATION			
Where did the injury/accident happen? (e.g., Main St., Post Office, Parking Lot)			
Nature of the injury? (Burn, laceration, bump, fracture, etc.)			
Provide details of the nature of your injury. List all body parts affected (e.g., twisted left ankle and cut forehead)			
Was this your usual work location?	YES	NO	If not, why were you there?
What were you doing when you were injured? (e.g., unloading truck, typing a report, etc.)			

Revision History: rev. #3, 9/21/2021, replaces rev.#1, 5/2018 and rev. #2 3/25/2020

Town of Long Lake, NY
Accident/Incident/Near-Miss Report

INSTRUCTIONS
Complete all sections of form within 24 hours of the accident/incident/near-miss. Return to Workers' Compensation (WC) Administrator at the Town Offices.
How did the injury happen? (e.g., tripped over a pipe and fell to floor)
Was an object involved in the injury? Please list (e.g., hammer, needle, plow)
What Personal Protective Equipment (PPE) were you using? Please list.

Was the accident/injury a result of the use or operation of a licensed motor vehicle?		YES	NO
YES	Your vehicle? If yes, provide make/model and your insurance carrier's name and address. Describe any damage.		
NO			
YES	Employer's vehicle? If yes, provide make/model. Describe any damage.		
NO			
YES	Other vehicle? If yes, provide name of owner, make/model, and insurance information. Describe any damage.		
NO			

SIGNATURES		
Name of employee or person completing form:	Signature:	Date:
Supervisor's Name:	Signature:	Date:
Receipt by WC Administrator:	Signature:	Date:

ATTACHMENTS
Provide list of attachments (e.g., pictures, medical receipts, witness statements, corrective actions, additional report pages, other)

REVIEW AND COMMENTS			
Safety Coordinator Review:	Date:	PESH Recordable	WC Case
Safety Committee Review:		Date:	
Corrective Action:		Date Completed:	

Revision History: rev. #3, 9/21/2021, replaces rev.#1, 5/2018 and rev. #2 3/25/2020