VOLUNTEERS CHECK ONE:

FIRE DEPARTMENT ☐ AMBULANCE ☐

FOR USE BY FIRE/AMBULANCE COMPANIES ONLY SULLIVAN COUNTY WORKERS COMPENSATION PROGRAM EMPLOYEE ACCIDENT AND ILLNESS FORM

03.01.2025

VOLUNTEER'S LAST NAME: _____

VOLUNTEER'S FIRST NAME: _____ **MI:** _____

SS#: _____ **DATE OF BIRTH:** _____ **AGE:** _____

ADDRESS: _____

CITY _____ **STATE** _____ **ZIP CODE** _____

NAME AND ADDRESS OF FIRE/AMBULANCE COMPANY: _____

DATE OF ACCIDENT/INJURY: _____ **TIME:** _____ **DATE SUPERVISOR NOTIFIED:** _____

LOCATION OF ACCIDENT/INJURY: _____

VOLUNTEER'S REGULAR EMPLOYER:

ADDRESS: _____

HAS VOLUNTEER RETURNED TO REGULAR EMPLOYMENT: **YES** ☐ **NO** ☐ **FIRST DATE OF LOST TIME:** _____

DETAILED VOLUNTEER STATEMENT: _____

Nature of Injury and Body Part(s) Affected: _____

What Was Volunteer Doing and How Did Injury Occur?: _____

WAS PROTECTIVE EQUIPMENT PROVIDED: YES ☐ NO ☐ **WAS PROTECTIVE EQUIPMENT IN USE:** YES ☐ NO ☐

WAS EQUIPMENT DEFECTIVE: YES ☐ NO ☐

IS THIS A RECURRENCE OF A PRIOR INJURY OR ILLNESS? YES ☐ (IF YES, PROVIDE DETAILS) _____ NO ☐

SIGNATURE OF VOLUNTEER: _____ **PHONE#:** _____ **DATE SIGNED:** _____

SUPERVISOR'S STATEMENT: _____ **DO YOU CONFIRM THIS INJURY OR ILLNESS:** YES ☐ NO ☐

Name of Witness: _____ Signature of Witness: _____

Did Employee Seek Medical Treatment: YES ☐ NO ☐

Medical Treatment Provided to Employee: _____ Date of Treatment: _____ Any EMT/Ambulance Used: YES ☐ NO ☐

Name of Hospital/Physician: _____

Address: _____

SIGNATURE OF SUPERVISOR: _____

PRINT NAME: _____ **PHONE#:** _____

MAIL/FAX COMPLETED FORM TO: RM@sullivanny.gov

DATE STAMP

SC RISK MANAGEMENT DEPT.
PO BOX 5012
MONTICELLO, NEW YORK 12701

FAX: (845) 807-0480
Email: RM@sullivannygov

RISK MANAGEMENT OFFICE ONLY

ACCOUNT CODE: _____