VOLUNTEERS CHECK ONE:
FIRE DEPARTMENT ____ AMBULANCE ____

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

VOLUNTEERS LAST NAME, 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:

Volunteers Regular Employer: _____ Address _____

Has Volunteer Returned to Regular Employement: ____ 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? No ____ Yes ____ IF YES PROVIDE DETAILS _____

SIGNATURE OF VOLUNTEER _____ PHONE# _____ SIGNED _____

Supervisors 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 _____ **DATE SIGNED** _____

PRINT NAME **PHONE #**

MAIL/FAX COMPLETED FORM TO: RM@sullivannygov **DATE STAMP**

RISK MANAGEMENT OFFICE ONLY

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

ACCOUNT CODE _____

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