

EHS-026 F1 R3

OSHA 301 Equivalent Fields

<b>Workplace Violence Report</b>	<b>Y</b>	<b>N</b>	<b>(10) OSHA 301 Case Number from Log (HR):</b>	NYS ARS Number (1-888-800-0029):	Report ID (EHS assigned):
					Report Date:

Campus	<b>(11) Date of Incident (injury/illness):</b>	<b>(13) Time of Incident (HH:MM) note AM/PM</b>	Did accident involve personal injury? (Y/N)		
2827 - SUNY Poly			<-- Check if unknown		
<b>Victim Information:</b>					
<b>(1) Victim Last Name</b>	<b>(1) Victim First Name</b>	<b>(1) Victim MI</b>	<b>(5) Gender:</b>	<b>Female</b>	<b>(3) Date of Birth (m/d/y)</b>
			<b>Male</b>		
			<b>Other</b>		ID Number:
Job Title	<b>(4) Date Hired (m/d/y)</b>	<b>(12) Time employee began work (HH:MM) A/P</b>	Bargaining Unit		
Marital Status	A - Single	<b>(2) Home Address:</b>		Campus Address / Office:	
	B - Married	# / Street	Office / Room #:		Reporter of Accident
	C - Separated	City / State	Building:		A - Faculty / Staff
	D - Divorced	Zip	Phone 1:		B - Victim
	E - Unknown	Phone 1	Phone 2:		C - UP
	Phone 2	Email:		D - HWC	17d. Reporter Contact Information:
	Email			E - Other	# / Street / Office
					City / State
					Phone 1
					Phone 2
					Email

<b>Injury Information:</b>					
Was victim in authorized area?	Yes	No	Indicate Specific area of Occurrence (room, area, unit, etc...)	<b>(16) Location of Bodily Injury (note specifics e.g. Rt / Lt, which finger)</b>	
General area of Occurrence	F - Athletic Field / Concession			A - Abdomen	J - Foot
A1 - Adirondack Dorm	G - Kunsela			B - Ankle	K - Hand
A2 - Mohawk Dorm	H - Library			C - Arm	L - Head
A3 - Oriskany Dorm	I - Facilities Main	24a. Accident/ Injury Circumstances		D - Back	M - Hip
A4 - Hilltop Dorm	J - Facilities - Vehicle	A - Athletic		E - Chest	N - Knee
B - Campus Center	K - Facilities - Generator	B - Academic		F - Elbow	O - Leg
C - Student Center	L - Parking Lot	C - Job Related		G - Eye	P - Lip
D - Donovan	M - Road / Sidewalk	D - Other		H - Face	Q - Neck
E - Field House	N - Grounds			I - Finger	R - Nose
					S - Shoulder
					T - Spine
					U - Teeth
					V - Thigh
					W - Toes
					X - Trunk
					Y - Wrist
					Z - Other - specify -->

<b>(18) If Physical Injury, extent:</b>	<b>(6) (8) Medical Assistance provided</b>	<b>(16) If Physical Injury, type of injury</b>
A - Fatal (18)	A - 1st Aid by Staff	A - Abrasion
B - Major	B - HWC	G - Cut
C - Minor (at time of incident)	C - Urgent Care	H - Dislocation
D - Unknown (at time of incident)	D - Primary Care Physycian	I - Fracture
	E - Ambulance	J - Laceration
	<b>F - Hospital / Emergency Room (8)</b>	K - Puncture
	G - Other	L - Swelling
	H - None	M - Tooth (broken)
		N - Sprain
		O - Strain
		P - Other (specify) -->

<b>(6/7) Attending Physician Information</b>	<b>(7) Hospital / Urgent Care Information if treatment given off-campus</b>	<b>(17) Other Injury Related Information - What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." In cases of strains, the thing(s) person was lifting, pulling, etc.). If this question does not apply to the incident, leave it blank.</b>
Name	Facility Name	
Office Name	# / Street	
# / Street	City	
City / State	Zip	
Zip	Phone 1	
Phone 1	Fax	
Fax		
Email	<b>(18) If employee dies, Date of Death (m/d/y):</b>	

<b>Other Information:</b>					
<b>(9) Was employee hospitalized overnight/in-patient?</b>	Yes	No	N/A	Explain	
Were safeguards provided?	Yes	No	N/A	Explain	
Any Witnesses? (contact info in Narrative)	Yes	No	List		
Did Employee leave work after injury?	Yes	No	Date returned to work	Indicate Dates off due to injury:	
Employee has restricted duties (Rx)?	Yes	No	Explain		

<b>Supervisor Information:</b>					
Was Supervisor Notified?	Yes	No	Date of Notification:	Time of Notification:	Supervisor's Name:

**(15) SUMMARY OF INCIDENT / NARRATIVE - What Happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time." Give description of who, what, where, when, how, etc. Describe fully the events that resulted in injury or occupational disease. List witnesses names and addresses. WHAT WAS PERSON DOING WHEN INJURED? (BE SPECIFIC; identify tools, equipment or material the person was using).**

Report completed by:	Title	Date:
Safety Supervisor Signature:	Title	Date: