NEW YORK STATE | Office of Mental Health

ACCIDENT/INJURY REPORT

SECTION I: TO BE COMPLETED BY INJURED PERSON

Accident/Injury occurred to: ☒ State Employee ☐ Non-State Employee

If Employee is unable to complete, the Supervisor should complete Sections I & II. If Non-Employee is unable to complete this form, the Facility Safety Department should complete Section I. Once completed, please forward to the Human Resources Management Office. *(Detailed instructions for completing this form can be found on Page 4.)*

Employee/Supervisor must call the Accident Reporting System (ARS) at (888) 800-0029.	ARS#:

Name: *Last, First M.I.*	Unit/Department	Work Hours: Shift:	Pass Days
Thome, James H		☒ Full-Time ☐ Part-Time ☐ AWS	&

Home Address: *Street City State Zip*	Date of Birth	Home/Cell Phone	Work Phone
	08/27/1970		

Negotiating Unit: ☐ CSEA ☒ PEF ☐ M/C ☐ NYSCOPBA* ☐ Council 82* ☐ None/Non-State Employee

*NYSCOPBA & Council 82 **must** complete a Benefit Election Form

Title	Item No.	NYS Employee ID #	Date Hired:
		N	

Date of Accident/Injury: *(MM/DD/YYYY)*	Day of Week:	Time of Accident:
11/1/23	☐ Mon ☐ Tue ☒ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun	2:00 ☐ AM ☒ PM

1. LOCATION OF ACCIDENT/INJURY: ☒ On Facility Property ☐ Off Facility Property

Address or Location	Building No.	Unit/Ward No.	Floor	Room No.
123 Fake Street				

Check the one that best applies:

☐ Grounds ☒ Outside Building ☐ Kitchen/Dining Room ☐ Bedroom ☐ Program/Activity Area ☐ Vehicle
☐ Stairs ☐ Hallway ☐ Plant Facilities ☐ Bathroom/Shower ☐ Restraint/Seclusion Room ☐ Dayroom
☐ Other *(Please describe):* _____

2. PATIENT RELATED ACCIDENT/INJURY: Did Incident Involve a Patient? ☐ Yes ☒ No Patient's C#: _____
(If No, skip to Part 3; If Yes, you must also complete an Incident Report/OMH-147)

Please check box(es) which best describe cause or circumstances in which Accident/Injury occurred:

☐ During an Episode of Restraint/Seclusion ☐ During a Patient Fight ☐ Assisting with ADL
☐ During Administration of Medication/Treatment ☐ Lifting/Moving/Positioning a Patient ☐ Patient Assault
☐ During Limit Setting ☐ Calming Agitated Patient ☐ Other

Was injury a result of Patient Aggression? ☐ Yes ☐ No Was an Incident Report (OMH 147) filed? ☐ Yes ☐ No
Was weapon/dangerous instrument used? ☐ Yes ☐ No If yes, type? _____

3. NON-PATIENT RELATED ACCIDENT/INJURY: Cause or circumstance in which Accident/Injury occurred:

☐ Lifting/Carrying Supplies or Equipment ☐ Chemical Contact ☐ Opening/Closing Window or Door
☐ Moving/Transporting Equipment ☐ Insect Bite/Sting ☐ Other *(Describe):* _____
☒ Fall/Slip due to: ☒ Weather Condition ☐ Wet Floor ☐ Obstruction

4. NATURE OF INJURY: *(Check appropriate box)*

☒ Abrasion/Bruise/Cut ☐ Burn ☐ Animal Related ☐ Eye Injury ☐ Head Injury ☐ Bite
☐ Allergic Reaction ☐ Needle Stick ☐ Illness ☐ Other: _____
☐ Chemical Related ☐ Sprain/Strain/Fracture ☐ Blood/Body Exposure*
*Must complete Occupational Exposure Report

Body Part(s) Injured: *(Please be specific. Left, Right, Etc.)* Left hip/side.

Describe the incident: *(Please be specific. Attach additional sheets if necessary.)*

I was walking into the office. Ramp, wall and handrail entering the building was covered in ice/moisture and I slipped and fell on the way in. Bruised my hip.

NEW YORK STATE | Office of Mental Health

ACCIDENT/INJURY REPORT

Continued - SECTION I: TO BE COMPLETED BY INJURED PERSON

Name(s) of Witness(es) to the incident:		
Did you notify your supervisor? ☐ Yes ☐ No If Yes, Date/Time of notification:		
Signature of Injured Person:	Date:	Time: ☐ AM ☐ PM

SECTION II - TO BE COMPLETED BY FIRST AID PROVIDER (If Applicable): First Aid Provided? ☒ Yes ☐ No

Date First Aid provided: 11/1/23 Time: 2:30 ☐ AM ☒ PM

Please describe (in detail) the treatment provided:
James was examined and there were no signs of serious injury. Described his hip as "bruised" but was able to walk with help. James was provided with tylenol and instructed to see his doctor if pain continued. James went home for the day.

First Aid Provider's Signature:	Print Name/Title:	Date:

SECTION III – TO BE COMPLETED BY SUPERVISOR: *(If Non-State Employee, Safety Dept. will ensure completion)*

Date/Time Notified of Accident: Date: Time: ☐ AM ☐ PM

Did Employee remain on Duty? ☐ Yes ☐ No* *If No, what time did Employee Leave? _____

Was the employee working Overtime when Accident/Injury occurred? ☐ Yes ☐ No

Was the Accident/Injury a result of Workplace Violence? ☐ Yes ☐ No

Did the Accident/Injury involve a Motor Vehicle? ☐ Yes* ☐ No

*If Yes, Vehicle Year/Make/Model: License Plate #: Vehicle Owner: _____

Was Facility Safety Department called? ☐ Yes ☐ No If Yes, Blotter Entry #: _____

What condition(s) may have contributed to this Accident/Injury? *(Check appropriate box)*

☒ Environmental ☐ Work Practices ☐ Training ☐ Equipment ☐ Other: _____

Was/were conditions corrected? ☐ Yes ☐ No If No, why not? _____

Supervisor/Safety Department's Statement: *(Attach additional sheets as necessary)*

Corrective Action Taken:

Please Print Supervisor's Name/Title:

-OR-

Please Print Safety Officer's Name/Title:

Supervisor OR Safety Officer's Signature:	Date:	Time: ☐ AM ☐ PM

NEW YORK STATE | Office of Mental Health

ACCIDENT/INJURY REPORT

SECTION I: TO BE COMPLETED BY INJURED PERSON

Accident/Injury occurred to: ☐ State Employee ☐ Non-State Employee

If Employee is unable to complete, the Supervisor should complete Sections I & II. If Non-Employee is unable to complete this form, the Facility Safety Department should complete Section I. Once completed, please forward to the Human Resources Management Office. *(Detailed instructions for completing this form can be found on Page 4.)*

Employee/Supervisor must call the Accident Reporting System (ARS) at (888) 800-0029.	ARS#:

Name: *Last, First M.I.*	Unit/Department	Work Hours: Shift:	Pass Days
Ryan, Nolan	MLB	☐ Full-Time ☐ Part-Time ☒ AWS	&

Home Address: *Street City State Zip*	Date of Birth	Home/Cell Phone	Work Phone
	1/31/47		

Negotiating Unit: ☐ CSEA ☐ PEF ☒ M/C ☐ NYSCOPBA* ☐ Council 82* ☐ None/Non-State Employee

*NYSCOPBA & Council 82 **must** complete a Benefit Election Form

Title	Item No.	NYS Employee ID #	Date Hired:
		N	

Date of Accident/Injury: *(MM/DD/YYYY)*	Day of Week:	Time of Accident:
12/24/23	☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☒ Sun	☐ AM ☐ PM

1. LOCATION OF ACCIDENT/INJURY: ☐ On Facility Property ☐ Off Facility Property

Address or Location	Building No.	Unit/Ward No.	Floor	Room No.
123 Fake Street				

Check the one that best applies:

☒ Grounds ☒ Outside Building ☐ Kitchen/Dining Room ☐ Bedroom ☐ Program/Activity Area ☐ Vehicle
☐ Stairs ☐ Hallway ☐ Plant Facilities ☐ Bathroom/Shower ☐ Restraint/Seclusion Room ☐ Dayroom
☐ Other *(Please describe):* _____

2. PATIENT RELATED ACCIDENT/INJURY: Did Incident Involve a Patient? ☐ Yes ☒ No Patient's C#: _____
(If No, skip to Part 3; If Yes, you must also complete an Incident Report/OMH-147)

Please check box(es) which best describe cause or circumstances in which Accident/Injury occurred:

☐ During an Episode of Restraint/Seclusion ☐ During a Patient Fight ☐ Assisting with ADL
☐ During Administration of Medication/Treatment ☐ Lifting/Moving/Positioning a Patient ☐ Patient Assault
☐ During Limit Setting ☐ Calming Agitated Patient ☐ Other

Was injury a result of Patient Aggression? ☐ Yes ☐ No Was an Incident Report (OMH 147) filed? ☐ Yes ☐ No
Was weapon/dangerous instrument used? ☐ Yes ☐ No If yes, type? _____

3. NON-PATIENT RELATED ACCIDENT/INJURY: Cause or circumstance in which Accident/Injury occurred:

☐ Lifting/Carrying Supplies or Equipment ☐ Chemical Contact ☐ Opening/Closing Window or Door
☐ Moving/Transporting Equipment ☐ Insect Bite/Sting ☐ Other *(Describe):* _____
☒ Fall/Slip due to: ☒ Weather Condition ☐ Wet Floor ☐ Obstruction

4. NATURE OF INJURY: *(Check appropriate box)*

☐ Abrasion/Bruise/Cut ☐ Burn ☐ Animal Related ☐ Eye Injury ☐ Head Injury ☐ Bite
☐ Allergic Reaction ☐ Needle Stick ☐ Illness ☐ Other: _____
☐ Chemical Related ☒ Sprain/Strain/Fracture ☐ Blood/Body Exposure*
*Must complete Occupational Exposure Report

Body Part(s) Injured: *(Please be specific. Left, Right, Etc.)* left ankle

Describe the incident: *(Please be specific. Attach additional sheets if necessary.)*

slipped on large icicle which had fallen from gutter system onto base of ramp, fell and rolled ankle

NEW YORK STATE | Office of Mental Health

ACCIDENT/INJURY REPORT

Continued - SECTION I: TO BE COMPLETED BY INJURED PERSON

Name(s) of Witness(es) to the incident:		
Did you notify your supervisor? ☐ Yes ☐ No If Yes, Date/Time of notification:		
Signature of Injured Person:	Date:	Time: ☐ AM ☐ PM

SECTION II - TO BE COMPLETED BY FIRST AID PROVIDER (If Applicable): First Aid Provided? ☐ Yes ☒ No

Date First Aid provided: Time: ☐ AM ☐ PM

Please describe (in detail) the treatment provided:
Employee taken to hospital due to age and concern of break

First Aid Provider's Signature:	Print Name/Title:	Date:

SECTION III – TO BE COMPLETED BY SUPERVISOR: *(If Non-State Employee, Safety Dept. will ensure completion)*

Date/Time Notified of Accident: Date: Time: ☐ AM ☐ PM

Did Employee remain on Duty? ☐ Yes ☐ No* *If No, what time did Employee Leave? _____

Was the employee working Overtime when Accident/Injury occurred? ☐ Yes ☐ No

Was the Accident/Injury a result of Workplace Violence? ☐ Yes ☐ No

Did the Accident/Injury involve a Motor Vehicle? ☐ Yes* ☐ No

*If Yes, Vehicle Year/Make/Model: License Plate #: Vehicle Owner: _____

Was Facility Safety Department called? ☐ Yes ☐ No If Yes, Blotter Entry #: _____

What condition(s) may have contributed to this Accident/Injury? *(Check appropriate box)*

☒ Environmental ☐ Work Practices ☐ Training ☐ Equipment ☐ Other: _____

Was/were conditions corrected? ☐ Yes ☐ No If No, why not? _____

Supervisor/Safety Department's Statement: *(Attach additional sheets as necessary)*

Corrective Action Taken:

Please Print Supervisor's Name/Title:

-OR-

Please Print Safety Officer's Name/Title:

Supervisor OR Safety Officer's Signature:	Date:	Time: ☐ AM ☐ PM

NEW YORK STATE | Office of Mental Health

ACCIDENT/INJURY REPORT

SECTION I: TO BE COMPLETED BY INJURED PERSON

Accident/Injury occurred to: ☐ State Employee ☐ Non-State Employee

If Employee is unable to complete, the Supervisor should complete Sections I & II. If Non-Employee is unable to complete this form, the Facility Safety Department should complete Section I. Once completed, please forward to the Human Resources Management Office. *(Detailed instructions for completing this form can be found on Page 4.)*

Employee/Supervisor must call the Accident Reporting System (ARS) at (888) 800-0029.	ARS#:

Name: *Last, First M.I.*	Unit/Department	Work Hours: Shift:	Pass Days
Kinney, Laura	HHA	☒ Full-Time ☐ Part-Time ☐ AWS	&

Home Address: *Street City State Zip*	Date of Birth	Home/Cell Phone	Work Phone
	1/23/93		

Negotiating Unit: ☒ CSEA ☐ PEF ☐ M/C ☐ NYSCOPBA* ☐ Council 82* ☐ None/Non-State Employee

*NYSCOPBA & Council 82 **must** complete a Benefit Election Form

Title	Item No.	NYS Employee ID #	Date Hired:
		N	

Date of Accident/Injury: *(MM/DD/YYYY)*	Day of Week:	Time of Accident:
11/29//23	☒ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun	☐ AM ☐ PM

1. LOCATION OF ACCIDENT/INJURY: ☐ On Facility Property ☐ Off Facility Property

Address or Location	Building No.	Unit/Ward No.	Floor	Room No.
123 Fake Street				

Check the one that best applies:

☒ Grounds ☒ Outside Building ☐ Kitchen/Dining Room ☐ Bedroom ☐ Program/Activity Area ☐ Vehicle
☐ Stairs ☐ Hallway ☐ Plant Facilities ☐ Bathroom/Shower ☐ Restraint/Seclusion Room ☐ Dayroom
☐ Other *(Please describe):* _____

2. PATIENT RELATED ACCIDENT/INJURY: Did Incident Involve a Patient? ☐ Yes ☒ No Patient's C#: _____
(If No, skip to Part 3; If Yes, you must also complete an Incident Report/OMH-147)

Please check box(es) which best describe cause or circumstances in which Accident/Injury occurred:

☐ During an Episode of Restraint/Seclusion ☐ During a Patient Fight ☐ Assisting with ADL
☐ During Administration of Medication/Treatment ☐ Lifting/Moving/Positioning a Patient ☐ Patient Assault
☐ During Limit Setting ☐ Calming Agitated Patient ☐ Other

Was injury a result of Patient Aggression? ☐ Yes ☐ No Was an Incident Report (OMH 147) filed? ☐ Yes ☐ No
Was weapon/dangerous instrument used? ☐ Yes ☐ No If yes, type? _____

3. NON-PATIENT RELATED ACCIDENT/INJURY: Cause or circumstance in which Accident/Injury occurred:

☐ Lifting/Carrying Supplies or Equipment ☐ Chemical Contact ☐ Opening/Closing Window or Door
☐ Moving/Transporting Equipment ☐ Insect Bite/Sting ☒ Other *(Describe):* _____
☒ Fall/Slip due to: ☒ Weather Condition ☒ Wet Floor ☐ Obstruction

4. NATURE OF INJURY: *(Check appropriate box)*

☐ Abrasion/Bruise/Cut ☐ Burn ☐ Animal Related ☐ Eye Injury ☒ Head Injury ☐ Bite
☐ Allergic Reaction ☐ Needle Stick ☐ Illness ☐ Other: _____
☐ Chemical Related ☐ Sprain/Strain/Fracture ☐ Blood/Body Exposure*
*Must complete Occupational Exposure Report

Body Part(s) Injured: *(Please be specific. Left, Right, Etc.)* head

Describe the incident: *(Please be specific. Attach additional sheets if necessary.)*

icy ramp; fell and struck back of head; went to get testing; while still on ground Laura needed to be moved because of leak from roof/side of building causing her to get wet in extreme cold

NEW YORK STATE | Office of Mental Health

ACCIDENT/INJURY REPORT

Continued - SECTION I: TO BE COMPLETED BY INJURED PERSON

Name(s) of Witness(es) to the incident:		
Did you notify your supervisor? ☐ Yes ☐ No If Yes, Date/Time of notification:		
Signature of Injured Person:	Date:	Time: ☐ AM ☐ PM

SECTION II - TO BE COMPLETED BY FIRST AID PROVIDER (If Applicable): First Aid Provided? ☒ Yes ☐ No

Date First Aid provided: Time: ☐ AM ☐ PM

Please describe (in detail) the treatment provided:
Laura stabalized before moved; Employee taken to hospital due to head injury and potential concussion

First Aid Provider's Signature:	Print Name/Title:	Date:

SECTION III – TO BE COMPLETED BY SUPERVISOR: *(If Non-State Employee, Safety Dept. will ensure completion)*

Date/Time Notified of Accident: Date: Time: ☐ AM ☐ PM

Did Employee remain on Duty? ☐ Yes ☐ No* *If No, what time did Employee Leave? _____

Was the employee working Overtime when Accident/Injury occurred? ☐ Yes ☐ No

Was the Accident/Injury a result of Workplace Violence? ☐ Yes ☐ No

Did the Accident/Injury involve a Motor Vehicle? ☐ Yes* ☐ No

*If Yes, Vehicle Year/Make/Model: License Plate #: Vehicle Owner: _____

Was Facility Safety Department called? ☐ Yes ☐ No If Yes, Blotter Entry #: _____

What condition(s) may have contributed to this Accident/Injury? *(Check appropriate box)*

☒ Environmental ☐ Work Practices ☐ Training ☐ Equipment ☐ Other: _____

Was/were conditions corrected? ☐ Yes ☐ No If No, why not? _____

Supervisor/Safety Department's Statement: *(Attach additional sheets as necessary)*

Corrective Action Taken:

Please Print Supervisor's Name/Title:

-OR-

Please Print Safety Officer's Name/Title:

Supervisor OR Safety Officer's Signature:	Date:	Time: ☐ AM ☐ PM

NEW YORK STATE | Office of Mental Health

ACCIDENT/INJURY REPORT

SECTION I: TO BE COMPLETED BY INJURED PERSON

Accident/Injury occurred to: ☐ State Employee ☐ Non-State Employee

If Employee is unable to complete, the Supervisor should complete Sections I & II. If Non-Employee is unable to complete this form, the Facility Safety Department should complete Section I. Once completed, please forward to the Human Resources Management Office. *(Detailed instructions for completing this form can be found on Page 4.)*

Employee/Supervisor must call the Accident Reporting System (ARS) at (888) 800-0029.	ARS#:

Name: *Last, First M.I.*	Unit/Department	Work Hours: Shift:	Pass Days
Clemens, Roger	TA	☒ Full-Time ☐ Part-Time ☐ AWS	&

Home Address: *Street City State Zip*	Date of Birth	Home/Cell Phone	Work Phone
	4/6/62		

Negotiating Unit: ☐ CSEA ☒ PEF ☐ M/C ☐ NYSCOPBA* ☐ Council 82* ☐ None/Non-State Employee

*NYSCOPBA & Council 82 **must** complete a Benefit Election Form

Title	Item No.	NYS Employee ID #	Date Hired:
		N	

Date of Accident/Injury: *(MM/DD/YYYY)*	Day of Week:	Time of Accident:
12/24/23	☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☒ Sun	☐ AM ☐ PM

1. LOCATION OF ACCIDENT/INJURY: ☐ On Facility Property ☐ Off Facility Property

Address or Location	Building No.	Unit/Ward No.	Floor	Room No.
123 Fake Street				

Check the one that best applies:

☒ Grounds ☒ Outside Building ☐ Kitchen/Dining Room ☐ Bedroom ☐ Program/Activity Area ☐ Vehicle
☐ Stairs ☐ Hallway ☐ Plant Facilities ☐ Bathroom/Shower ☐ Restraint/Seclusion Room ☐ Dayroom
☐ Other *(Please describe):* _____

2. PATIENT RELATED ACCIDENT/INJURY: Did Incident Involve a Patient? ☐ Yes ☒ No Patient's C#: _____
(If No, skip to Part 3; If Yes, you must also complete an Incident Report/OMH-147)

Please check box(es) which best describe cause or circumstances in which Accident/Injury occurred:

☐ During an Episode of Restraint/Seclusion ☐ During a Patient Fight ☐ Assisting with ADL
☐ During Administration of Medication/Treatment ☐ Lifting/Moving/Positioning a Patient ☐ Patient Assault
☐ During Limit Setting ☐ Calming Agitated Patient ☐ Other

Was injury a result of Patient Aggression? ☐ Yes ☐ No Was an Incident Report (OMH 147) filed? ☐ Yes ☐ No
Was weapon/dangerous instrument used? ☐ Yes ☐ No If yes, type? _____

3. NON-PATIENT RELATED ACCIDENT/INJURY: Cause or circumstance in which Accident/Injury occurred:

☐ Lifting/Carrying Supplies or Equipment ☐ Chemical Contact ☐ Opening/Closing Window or Door
☐ Moving/Transporting Equipment ☐ Insect Bite/Sting ☐ Other *(Describe):* _____
☒ Fall/Slip due to: ☒ Weather Condition ☐ Wet Floor ☐ Obstruction

4. NATURE OF INJURY: *(Check appropriate box)*

☒ Abrasion/Bruise/Cut ☐ Burn ☐ Animal Related ☐ Eye Injury ☐ Head Injury ☐ Bite
☐ Allergic Reaction ☐ Needle Stick ☐ Illness ☐ Other: _____
☐ Chemical Related ☒ Sprain/Strain/Fracture ☐ Blood/Body Exposure*
*Must complete Occupational Exposure Report

Body Part(s) Injured: *(Please be specific. Left, Right, Etc.)* left knee

Describe the incident: *(Please be specific. Attach additional sheets if necessary.)*

jumping on ramp over icy ground, slipped and landed on left knee; tore pants and went home

NEW YORK STATE | Office of Mental Health

ACCIDENT/INJURY REPORT

Continued - SECTION I: TO BE COMPLETED BY INJURED PERSON

Name(s) of Witness(es) to the incident:		
Did you notify your supervisor? ☐ Yes ☐ No If Yes, Date/Time of notification:		
Signature of Injured Person:	Date:	Time: ☐ AM ☐ PM

SECTION II - TO BE COMPLETED BY FIRST AID PROVIDER (If Applicable): First Aid Provided? ☐ Yes ☒ No

Date First Aid provided: Time: ☐ AM ☐ PM

Please describe (in detail) the treatment provided:

First Aid Provider's Signature:	Print Name/Title:	Date:

SECTION III – TO BE COMPLETED BY SUPERVISOR: *(If Non-State Employee, Safety Dept. will ensure completion)*

Date/Time Notified of Accident: Date: Time: ☐ AM ☐ PM

Did Employee remain on Duty? ☐ Yes ☐ No* *If No, what time did Employee Leave? _____

Was the employee working Overtime when Accident/Injury occurred? ☐ Yes ☐ No

Was the Accident/Injury a result of Workplace Violence? ☐ Yes ☐ No

Did the Accident/Injury involve a Motor Vehicle? ☐ Yes* ☐ No

*If Yes, Vehicle Year/Make/Model: License Plate #: Vehicle Owner: _____

Was Facility Safety Department called? ☐ Yes ☐ No If Yes, Blotter Entry #: _____

What condition(s) may have contributed to this Accident/Injury? *(Check appropriate box)*

☒ Environmental ☐ Work Practices ☐ Training ☐ Equipment ☐ Other: _____

Was/were conditions corrected? ☐ Yes ☐ No If No, why not? _____

Supervisor/Safety Department's Statement: *(Attach additional sheets as necessary)*

Corrective Action Taken:

Please Print Supervisor's Name/Title:

-OR-

Please Print Safety Officer's Name/Title:

Supervisor OR Safety Officer's Signature:	Date:	Time: ☐ AM ☐ PM

NEW YORK STATE | Office of Mental Health

ACCIDENT/INJURY REPORT

SECTION I: TO BE COMPLETED BY INJURED PERSON

Accident/Injury occurred to: ☐ State Employee ☐ Non-State Employee

If Employee is unable to complete, the Supervisor should complete Sections I & II. If Non-Employee is unable to complete this form, the Facility Safety Department should complete Section I. Once completed, please forward to the Human Resources Management Office. *(Detailed instructions for completing this form can be found on Page 4.)*

Employee/Supervisor must call the Accident Reporting System (ARS) at (888) 800-0029.	ARS#:

Name: *Last, First M.I.*	Unit/Department	Work Hours: Shift:	Pass Days
Thomas, Franklin E.		☐ Full-Time ☐ Part-Time ☐ AWS	&

Home Address: *Street City State Zip*	Date of Birth	Home/Cell Phone	Work Phone
	5/27/1968		

Negotiating Unit: ☐ CSEA ☐ PEF ☐ M/C ☐ NYSCOPBA* ☐ Council 82* ☐ None/Non-State Employee

*NYSCOPBA & Council 82 **must** complete a Benefit Election Form

Title	Item No.	NYS Employee ID #	Date Hired:
		N	

Date of Accident/Injury: *(MM/DD/YYYY)*	Day of Week:	Time of Accident:
11/2/23	☐ Mon ☐ Tue ☐ Wed ☒ Thu ☐ Fri ☐ Sat ☐ Sun	☐ AM ☐ PM

1. LOCATION OF ACCIDENT/INJURY: ☐ On Facility Property ☐ Off Facility Property

Address or Location	Building No.	Unit/Ward No.	Floor	Room No.

Check the one that best applies:

☐ Grounds ☒ Outside Building ☐ Kitchen/Dining Room ☐ Bedroom ☐ Program/Activity Area ☐ Vehicle
☐ Stairs ☐ Hallway ☐ Plant Facilities ☐ Bathroom/Shower ☐ Restraint/Seclusion Room ☐ Dayroom
☐ Other *(Please describe):* _____

2. PATIENT RELATED ACCIDENT/INJURY: Did Incident Involve a Patient? ☐ Yes ☒ No Patient's C#: _____
(If No, skip to Part 3; If Yes, you must also complete an Incident Report/OMH-147)

Please check box(es) which best describe cause or circumstances in which Accident/Injury occurred:

☐ During an Episode of Restraint/Seclusion ☐ During a Patient Fight ☐ Assisting with ADL
☐ During Administration of Medication/Treatment ☐ Lifting/Moving/Positioning a Patient ☐ Patient Assault
☐ During Limit Setting ☐ Calming Agitated Patient ☐ Other

Was injury a result of Patient Aggression? ☐ Yes ☐ No Was an Incident Report (OMH 147) filed? ☐ Yes ☐ No
Was weapon/dangerous instrument used? ☐ Yes ☐ No If yes, type? _____

3. NON-PATIENT RELATED ACCIDENT/INJURY: Cause or circumstance in which Accident/Injury occurred:

☐ Lifting/Carrying Supplies or Equipment ☐ Chemical Contact ☐ Opening/Closing Window or Door
☒ Moving/Transporting Equipment ☐ Insect Bite/Sting ☐ Other *(Describe):* _____
☒ Fall/Slip due to: ☐ Weather Condition ☐ Wet Floor ☒ Obstruction

4. NATURE OF INJURY: *(Check appropriate box)*

☒ Abrasion/Bruise/Cut ☐ Burn ☐ Animal Related ☐ Eye Injury ☐ Head Injury ☐ Bite
☐ Allergic Reaction ☐ Needle Stick ☐ Illness ☐ Other: _____
☐ Chemical Related ☒ Sprain/Strain/Fracture ☐ Blood/Body Exposure*
*Must complete Occupational Exposure Report

Body Part(s) Injured: *(Please be specific. Left, Right, Etc.)* Right ankle

Describe the incident: *(Please be specific. Attach additional sheets if necessary.)*

Was carrying in boxes from my truck and couldn't see where I was going. Stepped in a hole on the ramp, lost my footing, and fell, breaking my ankle and injuring my side.

Franklin is Big Hurt.

NEW YORK STATE | Office of Mental Health

ACCIDENT/INJURY REPORT

Continued - SECTION I: TO BE COMPLETED BY INJURED PERSON

Name(s) of Witness(es) to the incident:		
Did you notify your supervisor? ☐ Yes ☐ No If Yes, Date/Time of notification:		
Signature of Injured Person:	Date:	Time: 7:30 ☒ AM ☐ PM

SECTION II - TO BE COMPLETED BY FIRST AID PROVIDER (If Applicable): First Aid Provided? ☐ Yes ☐ No

Date First Aid provided: Time: ☐ AM ☐ PM

Please describe (in detail) the treatment provided:
Franklin was unable to get up by himself, ankle seemed badly injured. Franklin refused medical attention, stating that he, "Had a miracle supplement at home," that would "make him as good as new."

First Aid Provider's Signature:	Print Name/Title:	Date:

SECTION III – TO BE COMPLETED BY SUPERVISOR: *(If Non-State Employee, Safety Dept. will ensure completion)*

Date/Time Notified of Accident: Date: Time: ☐ AM ☐ PM

Did Employee remain on Duty? ☐ Yes ☒ No* *If No, what time did Employee Leave? _____

Was the employee working Overtime when Accident/Injury occurred? ☐ Yes ☐ No

Was the Accident/Injury a result of Workplace Violence? ☐ Yes ☐ No

Did the Accident/Injury involve a Motor Vehicle? ☐ Yes* ☐ No

*If Yes, Vehicle Year/Make/Model: License Plate #: Vehicle Owner: _____

Was Facility Safety Department called? ☐ Yes ☐ No If Yes, Blotter Entry #: _____

What condition(s) may have contributed to this Accident/Injury? *(Check appropriate box)*

☒ Environmental ☒ Work Practices ☐ Training ☐ Equipment ☐ Other: _____

Was/were conditions corrected? ☐ Yes ☐ No If No, why not? _____

Supervisor/Safety Department's Statement: *(Attach additional sheets as necessary)*

Corrective Action Taken:

Please Print Supervisor's Name/Title:

-OR-

Please Print Safety Officer's Name/Title:

Supervisor OR Safety Officer's Signature:	Date:	Time: ☐ AM ☐ PM

NEW YORK STATE | Office of Mental Health

ACCIDENT/INJURY REPORT

SECTION IV: WITNESS STATEMENT *(Attach additional sheets as needed)*			
Please have each witness complete a separate Witness Statement. Please be as descriptive as possible.			
Witness Name: Jordan Davis	Title: programming specialist	Home/Cell Phone:	Work Phone:
Work Location: 123 Fake Street		Shift:	Pass Days:
Name of Employee(s) involved in incident: Franklin Thomas		Date of Incident: 11/2/23	

Description of Incident: *(Describe in detail what you observed. Please be specific.)*

Poor Franky fell and his ankle snapped and the sound was the worst thing I've ever heard. All this right after my wife left me and took the truck and dog, this was just too much and I need to see my psychiatrist.

Witness Signature:	Date: 11/2/23	Time: 3 ☐ AM ☒ PM

INSTRUCTIONS FOR COMPLETING ACCIDENT/ INJURY REPORT

NEW YORK STATE | Office of Mental Health

ACCIDENT/INJURY REPORT

This Accident/Injury Report must be used to report ALL accidents or injuries incurred by employees and non-employees at all OMH facilities.

Procedure to follow in the event of an Accident/Injury:

1. **Immediately obtain proper medical care, if needed;**
2. **Injured person's Supervisor and/or the Safety Department* must be notified immediately;**
3. **If injured person is an employee, the Supervisor will ensure that this report is completed upon occurrence or when symptoms first present. Supervisor will hand deliver or Fax the completed report to Human Resources Management.**
4. **Employee/Supervisor will call the Accident Reporting System (ARS) and document ARS # on Form;**
5. **If the injured person is not an employee, the facility Safety Department is responsible for initiating and distributing this report. For off-campus sites, the Senior Site Administrator will be responsible for initiating this report and notifying the Safety Department.**

***IMPORTANT - The facility Safety Department MUST be called in the following cases:**

- **The accident involves a visitor or non-State employee;**
- **The accident involves a serious injury;**
- **If required per facility policies and procedures;**
- **A hazardous or potentially dangerous condition exists, e.g., icy walks;**
- **Hazardous materials or infection control incidents.**

SECTION I to be completed by injured person

(Supervisor will complete Section I if employee is unable to complete)

If injured person is an OMH Employee:

1. Notify your supervisor immediately and call the Accident Reporting System (ARS) at (888) 800-0029.
2. Complete Section I. Use an additional sheet if a more detailed explanation is necessary. If accident/injury involves a patient, include Patient C#. An Incident Reporting Form (NIMRS 1) may need to be completed when a patient is involved. (See NIMRS Manual)
3. Provide First Aid as soon as possible within the shift that the accident/injury occurs. The facility's First Aid Provider will complete Section II of this report.
4. Bring this report back to your Supervisor who will complete Section III. You will receive a copy for your records.
5. Should you need to seek medical attention, you will be required to submit medical documentation from your provider. Your medical documentation should include a date of injury, diagnosis, prognosis and estimated date of return to duty. Medical documentation should be submitted to your Human Resources Office as soon as possible.

If injured person is NOT a State employee:

6. The non-State employee will fill out Section I.
7. If accident/injury occurred on campus, the facility Safety Department will process the report.

If accident/injury occurred off-campus, the Senior Site Administrator will process this report and will Fax a copy of this report to the Safety Department.

SECTION II to be completed by individual that provided First Aid (If applicable)

1. Provide a detailed description of the first aid performed, and the body part(s) treated.
2. Give this form to the Employee, who will bring it to his/her Supervisor. If the injured person is NOT an Employee of OMH, the facility Safety Department will retain this form.

SECTION III to be completed by injured employee's Supervisor

(If non-employee, Safety insures completion)

1. Complete all entries in this section.
2. Have all witnesses complete Section IV (Witness Statement). Attach additional sheets as needed.
3. Review the accident and interview any witnesses when possible. It is the responsibility of the Supervisor/Safety Department to evaluate contributing conditions and recommend preventive/corrective action. Evaluate the following:
    a. Were applicable policies, procedures and performance/practice expectations adhered to?
    b. Was appropriate protective equipment available and utilized?
    c. Did any hazardous condition exist which contributed to the accident? If so, was it addressed and corrective action initiated immediately?
4. When the facility's Safety Department is called, request the Blotter Entry number (BE#).
5. Hand deliver, email, mail or Fax the ENTIRE completed report to the facility's Human Resources Management Office.