Initial Incident Report

Within 7 days of incident, employee/Supervisor must fill out form and send to james.belfiore@co.schoharie.ny.us or send inter-departmental mail.

Employee First Name | Middle Initial | Last Name

Date of Birth | Gender | Social Security Number

Employee Mailing Address | City | State | Zip Code

Employee Phone Number | Employment Status: Full Time ☐ Part Time ☐ | No. of Days Worked per Week

Employee Date of Hire | Job Title | Estimated Weekly Wage

Date of Injury | Time of Injury | AM ☐ PM ☐ | Initial Date Last Worked

Nature of Injury | Part of Body | Body Part Position: Left ☐ Right ☐

Cause of Injury

Accident/Injury Description

Accident Location/Organization Name | Accident Location Address | City | Zip Code

Witness Name | Witness Phone Number

Form Prepared by | Preparer's Phone Number

Date Form Completed