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 | M.I. | Last Name | Date of Injury

Employee Mailing Address | City | State | Zip Code

Employee Phone Number | Social Security Number | Hire Date | Birth Date

Gender | Job Title

Time of Injury | AM ☐ | PM ☐ | Average Weekly Wage | Days Worked Per Week

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

Accident/Injury Description

Accident Location/Organization Name | Accident Location Address

City | State | Zip Code

Witness Name | Witness Phone Number

Witness Name | Witness Phone Number

Form Prepared by | Preparer's Phone Number

Date Form Completed