

TOWN OF CORNING FIRE PERSONEL INCIDENT REPORT

The injured worker and Fire Department Risk Manager/Chief must complete and file this report with the Risk Management Department, Kim Feehan, Supervisor, Town of Corning 20 S. Maple St. Corning NY 14830, **WITHIN 24 HOURS of any injury.**

PART A: INJURED WORKER'S STATEMENT OF ACCIDENT/ILLNESS

Employee Name (Last Name, First Name):		Employee ID #:
Home address:		SSN:
Home phone:	Date of Birth:	Work phone:
Job Title:	If this was a vehicle accident, please provide accident report number from police department handling investigation: Agency/report #	
Date of occurrence:	Time of accident:	Location of injury occurrence:
How was injury incurred:		Time employee began work:
Were you ever treated for a similar condition before:		Body part(s) injured:
If yes, give details:		

RISK MANAGER/CHIEF SIGNATURE: _____

Employee's Signature: _____

Date: _____

Part B: FIRE DEPARTMENT RISK MANAGER/CHIEF STATEMENT

Injury:		
Name and address of hospital or physician:	Did injured worker receive medical treatment:	Date:
Object or machinery causing injury:		
Was there contact with any other person's blood or body fluid:		
If yes, name and address of source person:	Did weather conditions contribute to occurrence:	
How could a similar occurrence be avoided:	If yes, what were the weather conditions:	
Describe any unsafe practice:		
Name and phone number of witnesses (if any):		
Did injured worker lose time from work:	If yes, first full day of disability:	
Has the injured worker returned to work:	If yes, date returned:	
RISK MANAGER/CHIEF SIGNATURE: _____		

IF THE INJURED WORKER RETURNS TO WORK OR BECOMES DISABLED AFTER THIS FORM HAS BEEN FILED, IT IS IMPERATIVE RISK MANAGEMENT BE CALLED IMMEDIATELY @ 607-438-0728

Supervisor's Name: Kim Feehan	Signature:
Phone ext: 607-438-0728	Date Completed:
The Original and one copy of the Workers' Compensation Injury VF2/CF2 / & Incident Report Form are needed within 24 hours of the injury.	
<ol style="list-style-type: none"> 1. Original to: Risk Management, Town of Corning C/o Supervisor 20 South Maple Street Corning, NY 14830 Phone: 607 438-0728/ 607-936-6114 ex 5 Fax: 607-937-0779 supervisor@townofcorningny.org 2. Copy to be retained for the district/department records. 3. Copy to be retained by the Fire Department's Secretary/Record Retention Officer 	
<p>Upon injury of active duty fire personnel covered by the Town of Corning, it is the responsibility of the Fire Department's Risk Manager or designee to fill out the Incident form, VF2/CF2 (Workers Compensations form) and get the originals to the Town of Corning Supervisor within 24 hours.</p>	

Part A is to be completed by the injured worker immediately after he/she has reported any on-the-job injury to his/her supervisor. All questions must be answered. The employee's signature is required.

Part A is to be verified by the Supervisor.

Part B is to be completed and signed by the Fire Department Risk Manager/Chief. Discuss the occurrence in detail with the injured worker prior to completing this section. If you have any valid reason to believe the occurrence did not happen as described, use the word "Alleged" in your description of injury.

Town Supervisor must receive this report and the WC form within 24 hours, if either this form or the WC form are not received, the Town could incur a fine from New York State Workers Compensation of up to \$2500.00. If this fine occurs it will be the Fire Department's responsibility to pay this and any assessed fines by New York State Workers

Compensation within (7) SEVEN DAYS. If you have any questions regarding the filing of this form, contact THE Town Supervisor.