

VOLUNTEERS CHECK ONE:
FIRE DEPARTMENT _____ AMBULANCE _____

FOR USE BY FIRE/AMBULANCE COMPANIES ONLY
SULLIVAN COUNTY WORKERS COMPENSATION PROGRAM
EMPLOYEE ACCIDENT AND ILLNESS FORM 6/09

VOLUNTEERS LAST NAME, FIRST NAME MI SS#
DATE OF BIRTH _____ AGE _____
ADDRESS: _____ NAME AND ADDRESS OF FIRE/AMBULANCE COMPANY

CITY STATE ZIP CODE

DATE OF ACCIDENT/INJURY _____ TIME _____ DATE SUPERVISOR NOTIFIED _____

LOCATION OF ACCIDENT/INJURY: _____

Volunteers Regular Employer: _____ Address _____
Has Volunteer Returned to Regular Employment: YES _____ NO _____ FIRST DATE OF LOST TIME _____
DETAILED VOLUNTEER STATEMENT:
NATURE OF INJURY AND BODY PART (S) AFFECTED _____
WHAT WAS VOLUNTEER DOING AND HOW DID INJURY OCCUR: _____

WAS PROTECTIVE EQUIPMENT PROVIDED: YES _____ NO _____ WAS PROTECTIVE EQUIPMENT IN USE : YES _____ NO _____
WAS EQUIPMENT DEFECTIVE: YES _____ NO _____
Is this a recurrence of a prior injury or illness? No _____ Yes _____ IF YES PROVIDE DETAILS _____

SIGNATURE OF VOLUNTEER _____ DATE SIGNED _____

Supervisors Statement: DO YOU CONFIRM THIS INJURY OR ILLNESS YES _____ NO _____

How could this have been prevented? _____

Name of Witness _____ Signature of Witness _____

Did Employee seek medical treatment: Yes _____ No _____

Medical Treatment Provided to Employee: Date of Treatment _____ Any EMT/Ambulance Used: Yes _____ No _____

Name of Hospital/Physician _____

Address _____

SIGNATURE OF SUPERVISOR _____ DATE SIGNED _____
PRINT NAME _____ PHONE # _____

MAIL/FAX COMPLETED FORM TO: DATE STAMP RISK MANAGEMENT OFFICE ONLY
SC RISK MANAGEMENT DEPT. GASB# _____
PO BOX 5012 DEPT # _____
MONTICELLO, NEW YORK 12701 ORG# _____ OBJ# _____
(845) 807-0480—FAX

ONCE CLAIM SUBMITTED—PLEASE REFER QUESTIONS TO RMSCO INC. 1-800-359-2816

RMSCO INC. 80 WOLF RD, SUITE 403, ALBANY, NY 12205