

TCWC-1 (REV 5/06)
TIOGA COUNTY
WORKERS' COMPENSATION
ACCIDENT QUESTIONNAIRE
(TO BE COMPLETED BY EMPLOYER)

NAME OF INJURED PERSON:

EMPLOYER/DEPARTMENT:

DATE, TIME, AND LOCATION OF ACCIDENT:

DESCRIBE IN DETAIL WHAT THE EMPLOYEE WAS DOING AT TIME OF ACCIDENT AND HOW THE INJURY OCCURRED:

DESCRIBE IN DETAIL ANY EQUIPMENT OR OTHER PROPERTY THAT WAS BEING USED AT THE TIME OF THE ACCIDENT:

DID ANY OF THE EQUIPMENT MALFUNCTION? YES _____ NO _____
IF YES, DESCRIBE HOW IT MALFUNCTIONED:

NAME & ADDRESS OF ANY WITNESSES:

DESCRIBE EMPLOYEE'S CONDITION AFTER THE ACCIDENT:

LIST ANY REASONS WHY YOU FEEL THAT THIS CLAIM MAY NOT BE A WORKERS' COMPENSATION CLAIM:

PLEASE DESCRIBE ANY PRIOR OR PRE-EXISTING PHYSICAL CONDITIONS (WHETHER OR NOT RELATED TO WORKERS' COMPENSATION INJURIES) THAT THE EMPLOYEE MAY HAVE:

LIST ANY PRIOR WORK-RELATED ACCIDENTS/INJURIES THE EMPLOYEE HAS HAD:

**WHERE ANY SAFETY RULES OR REGULATIONS VIOLATED AT THE TIME OF THE ACCIDENT? YES _____ NO _____
IF YES, PLEASE EXPLAIN:**

PLEASE MAKE YOUR RECOMMENDATION/SUGGESTION AS TO HOW THE ACCIDENT COULD HAVE BEEN PREVENTED:

SUPERVISOR'S NAME (PRINT): _____

SUPERVISOR'S SIGNATURE: _____

DATE: _____

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT AMY POFF AT 687-8205

PLEASE RETURN TO:

**TIOGA COUNTY SELF-INSURANCE PLAN
56 MAIN STREET
OWEGO, NY 13827**