TCWC-2 (REV 2/02)
TIOGA COUNTY
WORKERS' COMPENSATION
ACCIDENT QUESTIONNAIRE
(TO BE COMPLETED BY EMPLOYEE)

NAME: **GENDER:**

EMPLOYER/DEPARTMENT:

DATE, TIME, AND LOCATION OF ACCIDENT:

WAS ACCIDENT ON EMPLOYER'S PREMISES? YES________ NO______
IF NO, WHERE DID ACCIDENT OCCUR:

NATURE OF INJURYAND BODY PART(S) AFFECTED:

DESCRIBE IN DETAIL WHAT YOU WERE DOING AT TIME OF ACCIDENT AND HOW THE INJURY OCCURRED:

DESCRIBE IN DETAIL ANY EQUIPMENT 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 WITNESSESS:

DESCRIBE YOUR CONDITION AFTER THE ACCIDENT:

DO YOU HAVE ANY PRIOR OR PRE-EXISTING PHYSICAL CONDITIONS RELATED OR UNRELATED TO WORKERS' COMPENSATION INJURIES?
YES________ NO________
IF YES PLEASE DESCRIBE:

HAVE YOU EVER HAD A PRIOR WORK-RELATED ACCIDENT/INJURY?
YES________ NO_________
IF YES PLEASE LIST WHEN, WHERE, AND PART(S) OF BODY INJURED:

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

HAVE YOU SOUGHT MEDICAL CARE FROM A DOCTOR OR HOSPITAL?
YES________ NO________

DATE OF TREATMENT:

PLACE OF TREATMENT:

NAME OF MEDICAL PROVIDER:

DATE/TIME YOU RETURNED TO WORK:
FULL-TIME_______ PART-TIME_________

NAME (PRINT):______________________________

SIGNATURE:________________________________

DATE:__________________________

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

PLEASE RETURN TO YOUR SUPERVISOR WITHIN 48 HOURS:

SUPERVISOR PLEASE RETURN TO:
TIOGA COUNTY SELF-INSURANCE PLAN
56 MAIN STREET
OWEGO, NY 13827