Telephonic #	ON THE JOB INJURY FORM page 1of 4	Report Date
_____		_____ /_____ /_____

Department must call in employee injury within 24 hours of injury (1-888-682-4301)

Injured Employee	1. Complete PART A - Employee Section and Differential Application upon occurrence of injury or recurrence of injury on duty 2. Make three (3) photocopies and keep one (1) copy
Supervisor	1. Complete PART A - Employee Section if employee is not available 2. Complete PART B - Department Section 3. Fax form within 24 hours to Workers' Comp Unit (718-694-3281/3807) 4. Send original form within 2 business days to Workers' Comp Unit, 130 Livingston, 10th fl. 5. *Department of Subways only* - Send form within 2 business days to IOD Unit, 130 Livingston, 6th fl. 6. *Department of Buses only* – Send form within 2 business days to DOB Safety, 25 Jamaica Avenue, Rm. 28H

PLEASE PRINT – FULLY ANSWER ALL QUESTIONS

EMPLOYEE'S AGENCY: MTA ___ NYCTA ___ MABSTOA ___ SIRTOA ___ UNION AFFILIATION: _____

PART A - EMPLOYEE SECTION

(if employee is not available, Supervisor must complete this section and sign form)

Name: Last _____ First _____ M.I. _____

Pass# _____ BSC# _____ Date of Birth ___/___/_____ Soc. Sec.# XXX–XX–___ ___ ___ ___

Home Address (& Apt. #) _____ City _____ State _____

Zip Code _____ Gender (M/F) ____ Home Phone # _____ Cell Phone # _____

Home Email Address _____ Job Title _____ Title Code _____ Date of Hire ___/___/____

Dept./Division _____ RCN # _____ Work Location _____

Name of Supervisor_____ Total Hrs. Worked 7 Days Prior to Injury _____

Work Status at Time of Injury: Full ___ Restricted ___ Tour / Hrs. of Duty: From _____ (AM/PM) To _____ (AM/PM)

Wages/Hr: _____ Scheduled Lunch: From _____ (AM/PM) To _____ (AM/PM) RDOs _____

DESCRIBE INJURY:

Date of injury ____/____/_____ Time of day employee began work on date of injury: _____ (AM/PM)

Time of injury: _____ (AM/PM) Date of Death (*if applicable*) ___/___/_____

Recurrence of Prior Injury? Y ___ N ___ Date of Prior Injury ____/____/_____

Location of Injury: County _____

☐ Train: # _____ Yard _____ Tower _____ Track # _____ Station _____ Shop _____

☐ Bus: # _____ Depot _____ Storeroom #_____ Street _____Vehicle #_____

☐ Other: (*give exact address*) _____

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_____		____/____/_____

Injured Employee's Name _____ *Pass#* _____

Describe in detail how the injury occurred. Indicate what you were doing at the time of the incident. Name the object, substance or condition which directly caused the injury. (*Attach an additional sheet(s) if necessary*)

_____

_____

_____

_____

Type of Injury (*burn, cut, fracture*) _____

Body part(s) affected (*right leg, left arm, head*) _____

Medical Treatment Requested? Y ___ N___ Date Notified Supervisor: ___/___/_____

Received Workers' Comp Statement of Rights? Y ___ N___

Received Injury on Duty Instruction Sheet? Y ___ N___

I declare under penalty of perjury, under the laws of the State of New York, that all statements contained in this On-the-Job-Injury form and any accompanying documents are true and correct, with full knowledge that all statements made herein are subject to investigation and that any false or dishonest answer to any question may be grounds for disciplinary action.

Employee Signature: _____ Date ___/___/_____

Supervisor Signature: _____ Date ___/___/_____
(if employee fails to sign)

FAMILY MEDICAL LEAVE ACT (FMLA)

Please be advised that in the event of a lost time injury greater than 30 days, lost time relating to the on-the- job injury will be designated as leave usage under the Family Medical Leave Act (FMLA) if you are otherwise eligible. This notice does not constitute a waiver of any right that the Transit Authority has to controvert the claimed on-the-job injury.

DIFFERENTIAL APPLICATION

Employee must sign Differential Application to begin processing. Signature does not denote agreement with Supervisor's Report nor Workers' Compensation determinations of eligibility. I understand that, in making this application for Differential Benefit, I have agreed that the Authority may seek to recoup the value of Differential Benefits paid from any judgment or settlement of an action against third parties I may institute as a result of this Injury. I hereby apply for payment of differential.

Employee's Name (please print) _____

Employee's Signature: _____ Date ___/___/___

WAIVER & ELECTION

Requesting Waiver & Election? Y ___ N___ If yes, Employee must complete Waiver & Election Form, and Department must submit the form within 2 business days.

Telephonic #	ON THE JOB INJURY FORM page 3 of 4	Report Date
_____		____/____/____

PART B - DEPARTMENT SECTION

(Supervisor must complete this section and sign form)

Injured Employee's Name _____ *Pass#* _____

Supervisor's Name: Last _____ First _____ M.I. ____

Pass# _____ BSC# _____ Work Location _____

Work Phone Number _____ Cell Phone Number _____

INJURY INFORMATION

Did you observe the injury? Y ___ N___ If no, Who reported the injury to you? _____

Describe in detail your knowledge of how the injury occurred. (*Attach an additional sheet(s) if necessary*)

_____

_____

_____

At the time of the injury was the employee performing job-related assigned duties? Y ___ N ___ Unknown ___

Was the employee working approved overtime? Y ___ N ___ Unknown ___

Did the employee appear fit for duty? Y ___ N ___ Unknown ___ If not, explain: _____

Did the employee stop working? Y ___ N___ Date Stopped Work: ___/___/____

Has the employee returned to work? Y ___ N___ Return to work date: ___/___/____

Date the employee reported to MAC for Drug/Alcohol Testing: ___/___/____

RESPONSE TO INJURY

Was first aid given? Y ___ N___ If yes, describe the type of first aid: _____

Who was first at the injury scene? Name: _____ Phone Number _____

Area secured/immediate hazard eliminated?

Y ___ Time: _____ (AM/PM) N ___ If not, why? _____

If treatment given away from worksite, where was it given? Name of Facility _____

Address _____ City _____ State _____ Zip Code _____

Was the employee transported by ambulance? Y ___ N___ Treated in E/R? Y ___ N___ Hospitalized? Y ___ N___

Name of doctor or health care professional: _____ Badge # (*if applicable*) _____

Telephonic # _____	**ON THE JOB INJURY FORM** page 4 of 4	**Report Date** ____/____/____

Injured Employee's Name _____ *Pass#* _____

FACT-FINDING

Did you speak to the injured employee? Y ___ N___ If yes, Date: ___/___/_____

Did anyone observe the injury or speak to or assist the employee? Y ___ N ___ Unknown ___ If yes, List:

Name _____ Title _____ Pass# _____ Phone # _____

Name _____ Title _____ Pass# _____ Phone # _____

Name _____ Title _____ Pass# _____ Phone # _____

☐ Photograph ☐ Sketch ☐ Video If checked, by whom? Name: _____ Date: ___/___/_____

ROOT CAUSE ANALYSIS: (Why did it happen? What actually caused the injury or incident?)

Was an object (e.g., equipment, tool) involved in the injury? Y ___ N___ If yes, what?_____

Was the equipment/tool defective or used improperly? Y___ N___ If yes, explain _____

Was a chemical or air contaminant involved? Y___ N___ If yes, what? _____

Did the employee follow the policies or procedures for the tasks being performed at the time of the injury? Y ___ N___

If no, please explain _____

Did the employee receive required training? Y___ N___ Unknown ___

Was required Personal Protective Equipment (PPE) used? Y___ N___

Did the employee's actions (e.g., horseplay, distracted, drug or alcohol use) contribute to the injury? Y ___ N___

If yes, please explain _____

Were there any conditions (e.g., poor housekeeping, insufficient lighting, weather (snow, rain, heat, cold), defects in walking/working surface) that contributed to the injury? Y___ N___

If yes, explain _____

Based on the above ROOT CAUSE ANALYSIS, what was the root cause of this incident?_____

Does this incident require additional investigation? Y ___ N___ If yes, please explain. (*Attach additional sheets if needed*)

_____

RECOMMENDATIONS TO PREVENT RECURRENCE (What can be done to prevent another similar injury?)

_____

Supervisor Signature: _____ Date ___/___/_____

Location Manager Name: _____ Signature: _____ Pass #_____