

**THE GRADUATE SCHOOL AND UNIVERSITY CENTER
OFFICE OF HUMAN RESOURCES
365 FIFTH AVENUE
NEW YORK, NEW YORK 10016**

PROTOCOL FOR EMPLOYEE INJURY OR ILLNESS

Employees are responsible for reporting any accidental injuries or work related illnesses to their supervisors **immediately**.

Responsibilities of the Employee:

Any accident or sudden illness that impairs functioning must be referred to **911**. If able, the employee may place the call himself/herself, or request it of the supervisor, a co-worker or a Security Officer. The Director of Security and Safety or his Assistant may be reached at extension 7760.

Conditions when 911 must be called are:

- * unconsciousness, however brief
- * chest pains
- * poisoning
- * incapacitating head, abdominal and other pain
- * impaired breathing
- * profuse bleeding
- * disorientation or impaired ambulation

Do not attempt to pick up or move an injured individual.

- Obtain medical treatment; inform physician that injury or illness is work related.
- If able, complete and submit to supervisor: an Employee Notice of Work Related Injury or Illness form (**see the reverse side**). If the employee is unable to complete the form or describe what occurred to a supervisor or co-worker, the individual assisting the injured employee should describe the facts known to the supervisor. S/he will complete the report.

Responsibilities of the Supervisor:

- Insure employee has received medical treatment, as requested. Contact the Office of Human Resources (OHR) at extension 7700 if emergency contact information such as the name of a physician or an emergency contact telephone number is required. Also, insure the Director of Security and Safety or his Assistant is notified when the injury or illness occurs once 911 is contacted.
- If employee was unable to complete the Employee Notice of Work Related Injury or Illness form, insure that it is completed and signed. Forward the completed form to the Office of Human Resources.

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 (212) 817-7700**

EMPLOYEE NOTICE OF WORK RELATED INJURY OR ILLNESS

Please answer all questions fully. Please return this form to room 8403.

Name of employee: _____
First
Middle
Last

Department: _____

Date of Injury/ Illness: _____

Nature and extent of Injury/ Illness: _____

Describe actions taken & by whom: _____

Does the illness appear to be work related? Yes No

If yes, please briefly describe the circumstances of the injury or illness, including the location, and anyone that may have observed the injury: _____

Did the employee remain at work? Yes No

Was supervisor informed? Yes No

Supervisor's Signature: _____ Date: _____

Supervisor's Name (please print): _____
(Supervisor should complete form if employee is not able)

 Employee's Signature

 Date