TCWC-1 (REV 1/24)
TIOGA COUNTY
WORKERS' COMPENSATION
ACCIDENT QUESTIONNAIRE
(TO BE COMPLETED BY EMPLOYER)

NAME OF INJURED PERSON:

EMPLOYER/DEPARTMENT:

DATE, TIME, AND LOCATION OF ACCIDENT:

TIME EMPLOYEE'S SHIFT BEGAN:

INDICATE THE DAYS OF THE WEEK EMPLOYEE WORKS:

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:

DESCRIBE EMPLOYEE'S CONDITION AFTER THE ACCIDENT:

LIST ANY REASONS WHY YOU FEEL THAT THIS CLAIM MAY NOT BE A WORKERS' COMPENSATON 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 QUESTIONS, PLEASE CONTACT TIOGA COUNTY BENEFITS OFFICE AT (607)687-8201.

PLEASE RETURN TO:

TIOGA COUNTY SELF-INSURANCE PLAN
ROOM 206
56 MAIN STREET
OWEGO, NY 13827
Fax (607) 223-7074
E-mail: parkel@tiogacountyny.gov