



PUBLIC EMPLOYER RISK MANAGEMENT ASSOCIATION, INC.

9 Cornell Road, Latham, NY 12110

Toll Free in US: 1-888-737-6269 • Fax: 1-877-737-6232 • Email: compforms@perma.org

ACCIDENT NOTIFICATION FORM

For "notification only" incidents or injuries requiring first aid treatment only

COMPLETE AND SUBMIT THIS FORM WITHIN 24 HOURS OF ACCIDENT

Please fax form to above number or email to compforms@perma.org

The C-2F form can be filed in lieu of this form and **MUST** be filed if the injury required more than first aid treatment, in accordance with Section 110 of NYS Workers' Compensation Law.

For coverage questions, please feel free to contact PERMA at the above address or phone number.

(Please print)

Injured Person: _____ Sex: M F

Employer's or Volunteer District's Name: _____

Home address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Home phone #: (____) _____ SS#: _____ DOB: _____

Dept: _____ Job title: _____ Dept. code (see reverse side): _____

Volunteer Paid If volunteer, who is your regular employer? _____

Employer contact name: _____ Employer contact phone #: (____) _____

Date of Injury: ____/____/____ Time of Injury: ____ AM / PM Date Employer Notified: ____/____/____

Name of Witness: _____

Description of injury, including body part injured and how injury occurred: _____

Where did injury/accident occur? _____

Describe medical treatment – If the injured person required treatment beyond first aid, please file a C-2F form within 10 days of notice: _____

Has employee returned to work? Yes No Return to work date: ____/____/____ Actual Expected

Weekly wage: _____ PT FT Will wages be continued during disability? Yes No

Based on restriction, the employee will be assigned the following status: Full Duty Transitional Duty

Supervisor: _____ Phone #: _____

Supervisor's Signature: _____ Date: ____/____/____

TO BE COMPLETED BY SUPERVISOR

PROVIDE A COPY OF THIS FORM TO: PERMA Member Claims Coordinator, Department, and Employee

