Sullivan County
Vol. Firefighters First Report of Injury
*** Indicates Required Field**

All (5) PAGES MUST BE COMPLETED 06/2020

****All Completed First Report of Injury Forms should be sent via email to:** rm@sullivanny.us **or FAX 845-807-0480**

Subdivision/District Information: CLAIM NUMBER -					
*Political Subdivision or Fire District:					
*Fire Company:					
***Insurance Carrier/Self-Insured Plan:**	**Sullivan County Self-Insured Plan. The Plans Third Party Administrator is CorVel Corp. Post Office Box 2249, Syracuse, New York, 13220 Direct: 1.800.346.6333 Fax: 866.727.5573 Injuries may be reported to the dedicated Sullivan County/CorVel Nurse Advocacy Line Toll-Free, 24 Hours a Day, 7 Days a Week. PH: 855-456-8910**				
*Fire District Street Address:					
*Fire District City, State, Zip:					
*Questioning Validity of Injury?					
Volunteer Firefighter Information:					
*First Name:		Middle Initial:		Suffix:	
*Last Name:					
*Street Address:					
*City, State, Zip:					
Email Address:					
*Phone Number:		*Gender:			
*Date of Birth:		*Age			
*Date of Hire/Service Term Began:					
Marital Status:					
*SSN or Other ID# [At Least 1 Required]:		*Wage Amount:	$		
*Regular Employer Name:					
*Regular Employer Address:					
*Regular Employer City, State & Zip:					
*Regular Occupation or Job Title:		Employment Status [If Less Than F/T, Number of Hours:			
Work Days Scheduled:					
*Number of Dependents:					

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Type of Work Week? [Standard, Fixed or Varied]:			
Regular Employment Duties:			
Regular Employment Supervisor or Contact:		Regular Employment Supervisor or Contact Number:	
Firefighter Injury Details:			
*Date of Injury:		*Time of Injury:	
*Date of First Knowledge of Injury [AKA: Date Employer Notified:		*Was Notice of Injury Given in Writing [Yes/No]:	
*Date Administrator Notified:		Whom Was Injury Reported to?	
Phone Number [Please Include Area Code]:			
*(Has Injury Resulted In Death? [If no, Please Skip Section]:		Date of Death:	
Nearest Relative Name:			
Relationship to Vol. Firefighter?			
Nearest Relative: Address			
Nearest Relative City, State & Zip			
Severity, Nature of Injury & Body Parts Injured:			
Severity of Injury [Minor, Moderate or Severe]:			
*Nature of Injury (Laceration, Sprain, Fracture):			

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*Body Parts Injured & Injures to Each Body Part [Please List All If Multiple. At Least 1 Physical Injury is Required]:	
Cause of Injury (Slip & Fall, Burn, MVA, Etc.): How Did the Injury or Exposure Occur?:	
Accident/Injury Description [What was Firefighter Doing when Injured]:	

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Accident:			
*Location of Accident:			
*Street Address Including City & Zip:			
*Accident Location Description:		*Description of Accident:	
*Witness(es):		*Witness(es) Phone Number [Please Include Area Codes]:	
*Safeguard/Protective Equipment Provided?		*Safeguard/Protective Equipment Used?	
*Was Protective Equipment in Use at the Time? [Yes/No]:			
*The Above-Named Volunteer Firefighter was Injured in the Line of Duty While Serving with His/Her Own Fire Company/Department? [Yes/No]:			
*The Above-Named Volunteer Firefighter, Member of Another Fire Department was Injured in the Line of Duty After His/Her Services had been Accepted by the Above-Named Fire Company/Department? [Yes/No]:			
Work Status:			
*Has Injured Firefighter Returned to Work with Regular Employment? [Yes/No]:		*Date Disability Began?	
Date District or Fire Company Knew of Disability:		Date Returned to Work or Expected to Return to Work:	
Return to Work Type [If Less than Full, Please Indicate]:		Light/Modified Duty Available?	
Medical Treatment:			
*Did Vol. Firefighter Seek Treatment? [Yes/No]		*If So Where:	
*Type of Treatment or Provider?		*Treating Physician Phone Number [with Area Code]:	
Date of First Treatment:		Date of Next Office Visit:	

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*Was Firefighter Hospitalized?		If Yes, Where?	
*Medical Authorization on File? Yes/No			

Additional Comments: [Please Use this Area to Indicate Additional Contacts, Witness, Injuries and or Details of The Injury].

Date of this Report?	

If Form is Submitted by Political Subdivision, Please Complete A & B Below.
If Form is Submitted by Third Party, Please Complete, A, B, C, & D Below.

A. Person Preparing Form of Supplying Information to Third Party?	
B. Title [Please Include Phone Number with Area Code]:	
C. If Report prepared by Third Party, Company Name and Address:	
D. Third Party Contact Name [Please Include Phone Number with Area Code]:	