

VOLUNTEERS CHECK ONE:  
FIRE DEPARTMENT \_\_\_\_\_ AMBULANCE \_\_\_\_\_

**FOR USE BY FIRE/AMBULANCE COMPANIES ONLY**  
**SULLIVAN COUNTY WORKERS COMPENSATION PROGRAM**  
**EMPLOYEE ACCIDENT AND ILLNESS FORM 6/2013**

VOLUNTEERS LAST NAME, FIRST NAME MI SS#  
DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ NAME AND ADDRESS OF FIRE/AMBULANCE COMPANY \_\_\_\_\_  
CITY STATE ZIP CODE

DATE OF ACCIDENT/INJURY \_\_\_\_\_ TIME \_\_\_\_\_ DATE SUPERVISOR NOTIFIED \_\_\_\_\_  
LOCATION OF ACCIDENT/INJURY: \_\_\_\_\_

Volunteers Regular Employer: \_\_\_\_\_ Address \_\_\_\_\_  
Has Volunteer Returned to Regular Employment: YES \_\_\_\_\_ NO \_\_\_\_\_ FIRST DATE OF LOST TIME \_\_\_\_\_  
**DETAILED VOLUNTEER STATEMENT:**  
NATURE OF INJURY AND BODY PART (S) AFFECTED \_\_\_\_\_  
WHAT WAS VOLUNTEER DOING AND HOW DID INJURY OCCUR: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
WAS PROTECTIVE EQUIPMENT PROVIDED: YES \_\_\_\_\_ NO \_\_\_\_\_ WAS PROTECTIVE EQUIPMENT IN USE : YES \_\_\_\_\_ NO \_\_\_\_\_  
WAS EQUIPMENT DEFECTIVE: YES \_\_\_\_\_ NO \_\_\_\_\_  
Is this a recurrence of a prior injury or illness? No \_\_\_\_\_ Yes \_\_\_\_\_ IF YES PROVIDE DETAILS \_\_\_\_\_

SIGNATURE OF VOLUNTEER \_\_\_\_\_ PHONE# \_\_\_\_\_ SIGNED \_\_\_\_\_

**Supervisors Statement:** DO YOU CONFIRM THIS INJURY OR ILLNESS YES \_\_\_\_\_ NO \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
How could this have been prevented? \_\_\_\_\_  
\_\_\_\_\_  
Name of Witness \_\_\_\_\_ Signature of Witness \_\_\_\_\_  
Did Employee seek medical treatment: Yes \_\_\_\_\_ No \_\_\_\_\_  
Medical Treatment Provided to Employee: Date of Treatment \_\_\_\_\_ Any EMT/Ambulance Used: Yes \_\_\_\_\_ No \_\_\_\_\_  
Name of Hospital/Physician \_\_\_\_\_  
Address \_\_\_\_\_

SIGNATURE OF SUPERVISOR \_\_\_\_\_ DATE SIGNED \_\_\_\_\_  
PRINT NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

MAIL/FAX COMPLETED FORM TO: DATE STAMP RISK MANAGEMENT OFFICE ONLY  
SC RISK MANAGEMENT DEPT. PO BOX 5012 MONTICELLO, NEW YORK 12701 (845) 807-0480-FAX  
GASB# \_\_\_\_\_  
ACCOUNT CODE \_\_\_\_\_

**ONCE CLAIM SUBMITTED—PLEASE REFER QUESTIONS TO POMCO INC. 1-877-236-7475**  
POMCO RISK MANAGEMENT, PO BOX 325, SYRACUSE, NEW YORK 13206-0325