

**Town of New Castle
Internal Incident Report Form**

eFROI (FROI-00) Worksheet (To be filled out by Immediate Supervisor)

Policyholder Information:	Town of New castle
* Policy number has to be active on Date of Accident being reported	23367774
* Policy mailing address and other contact information	Rober Deary, Town Comptroller 200 S. Greeley Ave, Chappaqua, NY 10514
* Name & email address of eFROI Initiator	
Broker/Safety Group Manager's email (optional)	Jennifer K. Ossenfort --- jossenfort@glatfelters.com
* Policy entity and policy work location(s)	200 S. Greeley Ave, Chappaqua, NY 10514
* Industry Type Code	Municipality / Public Entity

Injured Worker/Employee/Claimant Information

*Claimant's First and Last Name	
Social Security Number (optional)	
Personal information, such as *Date of Birth and *Gender	
*Claimant's address including zip code and telephone number	
*Did employee give notice of accident/illness? If so, to whom?	
Injured employee's supervisor's name	

Employment information:

Date of Hire	
*The claimant's gross average weekly wage	
Job Title	
*Claimant's usual days worked	
Time claimant started work on day of accident	
*Date claimant stopped working (due to injury)	
*Last day paid, if lost time case. (Provide the last calendar day the employee earned wages.)	
*Is employer continuing to pay claimant while out?	
Return To Work (RTW) information, date claimant RTW	
*If claimant RTW, with or without any restrictions?	
*Has employer provided the Claimant Information Packet and when?	

**Town of New Castle
Internal Incident Report Form**

*Claimant's First and Last Name	
Accident/Illness and Injury Information:	
*Date of the accident/illness or injury?	
*Time of injury?	
*What was employee doing at the time of injury?	
*How did the accident occur?	
*Where did the accident/illness happen?	
*Is the accident location the same as the policy location?	
If not, address location is required?	
*Did accident occur where the employee normally worked? If not, why was he/she there?	
*Nature of the injury (such as "Laceration" or "Fracture")	
*Body part(s) injured (up to six body parts may be selected)	
*Cause of injury	
*Type of Loss	
To your knowledge, did the employee have another work-related injury to the same body part or similar illness while working for you?	
Did the injury/illness result in the employee's death?	
eFROI (FROI-00) Worksheet	
*Was an object involved in the injury/illness?	
Was a lack of training or awareness a cause of the incident?	
Was a lack of proper Personal Protective Equipment or incorrect use of PPE a cause of the incident?	
Was an equipment failure or condition a contributory cause of the incident?	
Was the injury the result of the use or operation of a licensed motor vehicle?	
If accident involves the employer's motor vehicle, all automobile insurance information is required.	
*Did the claimant's supervisor see the injury?	
Any witnesses? If so, who?	
*What corrective actions have been taken or need to be taken to prevent similar future occurrences? attached additional sheet if more space is needed.	
Names, addresses, contact information for medical providers and/or hospitals from whom the injured worker received treatment	
If employee received medical care, on what date?	
WCB number also known as a JCN and if applicable, the OSHA accident number	
*Who is reporting this loss?	
*eFROI Initiator, Broker/Safety Group Mgr and Submitter's email addresses	

**Town of New Castle
Internal Incident Report Form**

*Claimant's First and Last Name	
Authorized Signature (To be filled out by Immediate Supervisor)	
Signature of Injured employee's supervisor	
Title	
Telephone	
Date of Report	