TCWC-2 (REV 1/24)
TIOGA COUNTY
WORKERS' COMPENSATION
ACCIDENT QUESTIONNAIRE
(TO BE COMPLETED BY EMPLOYEE)

NAME: **GENDER:**

EMPLOYER/DEPARTMENT:

DATE, TIME, AND LOCATION OF ACCIDENT:

WAS ACCIDENT ON EMPLOYER'S PREMISES? YES_____ NO_____
IF NO, WHERE DID ACCIDENT OCCUR:

NATURE OF INJURYAND BODY PART(S) AFFECTED:

DESCRIBE IN DETAIL WHAT YOU WERE DOING AT TIME OF ACCIDENT AND HOW THE INJURY OCCURRED:

DESCRIBE IN DETAIL ANY EQUIPMENT THAT WAS BEING USED AT THE TIME OF THE ACCIDENT:

DID ANY OF THE EQUIPMENT MALFUNCTION? YES_____NO_____
IF YES, DESCRIBE HOW IT MALFUNCTIONED:

NAME & ADDRESS OF ANY WITNESSESS:

DESCRIBE YOUR CONDITION AFTER THE ACCIDENT:

DO YOU HAVE ANY PRIOR OR PRE-EXISTING PHYSICAL CONDITIONS RELATED OR UNRELATED TO WORKERS' COMPENSATION INJURIES?
YES_____ NO_____

IF YES PLEASE DESCRIBE:

HAVE YOU EVER HAD A PRIOR WORK-RELATED ACCIDENT/INJURY?
YES_____ NO_____
IF YES PLEASE LIST WHEN, WHERE, AND PART(S) OF BODY INJURED:

PLEASE MAKE YOUR RECOMMENDATION/SUGGESTION AS TO HOW THIS ACCIDENT COULD HAVE BEEN PREVENTED:

HAVE YOU SOUGHT MEDICAL CARE FROM A DOCTOR OR HOSPITAL?
YES_____ NO_____

DATE OF TREATMENT:

PLACE OF TREATMENT:

NAME OF MEDICAL PROVIDER:

DATE/TIME YOU RETURNED TO WORK:_____

FULL-TIME_____ PART-TIME_____

NAME (PRINT):_____

SIGNATURE:_____

DATE:_____

IF YOU HAVE QUESTIONS, PLEASE CONTACT TIOGA COUNTY BENEFITS OFFICE AT (607)687-8201.

PLEASE RETURN TO YOUR SUPERVISOR WITHIN 48 HOURS:

SUPERVISOR 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