PUBLIC EMPLOYER RISK MANAGEMENT ASSOCIATION, INC.
P.O. Box 12250, Albany, NY 12212-2250
**Toll Free in US: 1-888-737-6269 • Fax: 1-877-737-6232 • Tel: (518) 220-1111**

SUBMIT THIS FORM ONLINE AT *WWW.PERMA.ORG*

PERMA

# *INITIAL REPORT*

**COMPLETE SECTION "A" AND SUBMIT THIS FORM WITHIN 24 HOURS OF ACCIDENT**

## SECTION A SUPERVISOR

***(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 Part time☐ Full time☐

Name of Witness: _____

Description of injury and how injury occurred: _____

_____

_____

Where did injury/accident occur? _____

_____

Describe medical treatment: _____

_____

_____

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

Weekly wage: _____ 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: _____/_____/_____

## SECTION B EMPLOYEE

Medical Authorization & Fraud Statement

In accordance with New York State law, I hereby authorize PERMA (or its representatives) to be furnished with any information or facts regarding this injury only, including records, diagnosis, medical treatment and prognosis, estimates of disability, and recommendations for further treatment. This information is to be used for the sole purpose of evaluating and handling any claim and medical care as a result of the incident occurring on or about the above noted date and for no other purpose, now or in the future.

**ANY PERSON** knowingly and with intent to defraud any coverage provider files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime.

Employee Signature:_____ Date: _____/_____/_____

## SECTION C MEDICAL PROVIDER

Name of Facility: _____ Date: _____/_____/_____

New Injury / Illness☐ Existing Condition ☐

Preliminary diagnosis:_____

Recommended work status: Full Duty☐ Transitional Duty☐ No Work☐

Modified duty restriction apply for: Lifting up to: _____lbs. Carrying limited to: _____lbs.

Pushing / Pulling limited to: _____lbs. No lifting☐ No carrying☐ No pushing / pulling☐

Other restrictions or comments: _____

Follow-up appointment with:_____ Date: ____/____/____ Time: _____AM _____PM

Physician / Clinician name (please print): _____ Phone #: (___)_____

Physician / Clinician Signature:_____ Date: _____/_____/_____

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

**AFTER SECTION "A" IS COMPLETE, PROVIDE A COPY OF THIS FORM TO:**

Injury Coordinator, Department, Medical Provider and Employee

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