

Attachment A

Accident / Injury Report Form – Non-employee

(Use when an accident or injury involves a County visitor or non-employee)



**County of Cayuga
Accident/Injury Report Non-Employee**

Name and address of Injured Person _____

Injured Persons Date of Birth _____ Phone Number _____

Parent of Legal Guardians Name _____

Address _____ Phone Number _____

Date of Injury or Accident _____ Time of Injury _____

Place of Injury (BE SPECIFIC) _____

Date and Time Injury/Accident reported to an Employee of Cayuga County _____

Were there any Witnesses? If so, Please give name, address and phone number of each witnesses

Type of Injury/Accident (Be Specific, (exactly what happened and what the Injury is) _____

Was an Ambulance called? _____ If so by whom? _____

Did the injured person see a Doctor? _____ If so, Please give the Doctors name, address, phone number and date of treatment _____

If the injured person was treated at a hospital, name of hospital, address and date of treatment

Name and phone no. of Individual supplying information for this report _____

Relationship of individual reporting info. on the injury/accident to the injured party _____

What measures could be taken to prevent a similar accident/incident from happening again? _____

Report taken by _____ (An employee of Cayuga County)

Received by _____ (Clerk of the Legislature Office)

Note to County Departments: this report when completed is to be immediately forwarded to the Clerk of the Legislature's Office, 160 Genesee St., 6th Floor, Auburn, NY – Phone 253-1498 Fax – 253-1586 e-mail - ssmith@cayugacounty.us

Attachment B

Work Related Injury/Illness Report/Investigation Forms

(Use when an accident involves a County employee)

CAYUGA COUNTY

INFORMATION (EMPLOYEE) FOR WORK RELATED INJURY/ILLNESS

1. Reporting Work Related Injuries & Illnesses

- Notify your immediate Supervisor/On-duty Supervisor
- Seek medical treatment, if necessary.
- Complete the Cayuga County Employee Report of Work Related Injury/Illness and submit to Supervisor within 48 hours on injury.

2. Medical Treatment

- Notify your immediate Supervisor/On-duty Supervisor if you must leave work for medical treatment.
- Seek a Workers' Compensation Board approved medical provider.
- Tell your provider that it is a work related injury and give them the information on the ID card below.
- In all accepted workers' compensation cases, your provider may not seek payment from you.
- Do NOT use your regular health benefits coverage card.
- You will receive an information packet in the mail with additional forms. Read and submit the forms as indicated in the packet.

Front of ID Card

WORKERS' COMPENSATION ID CARD	
	New York State Municipal Workers' Compensation Alliance 333 Earle Ovington Blvd., Suite 505 Uniondale, NY 11553-3624 Tel: (866) 697-6922 Fax: (516) 227-2352
www.compalliance.org	
Member Name: Member Since:	Cayuga County 01/01/09
	Valid until termination of membership
<i>See reverse side for important information.</i>	

Back of ID Card

<p>Attention Injured Employee</p> <p>This card is to be used solely for identification purposes for injuries sustained on the job. This is not a guarantee of payment. Use of this card for any other purpose is strictly prohibited.</p> <ol style="list-style-type: none">1. If you are injured on the job, it is important that you notify your supervisor immediately so that an injury report can be completed.2. Present this card to the treating physician or medical facility and indicate that the injury was sustained on the job.3. You are not responsible for any partial payments, co-pays or deductibles for work related injuries.
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If you have questions, please contact the payroll office at 253-1481 or 253-1323

Additional information on workers' compensation in New York can be found at: www.wcb.state.ny.us

3. If You Have To Be Out Of Work

- Tell your Supervisor within one business day that your provider has placed you out of work.
- You must submit the original provider's note taking you out of work.
- Update your department of your status after each provider appointment and submit a provider's note documenting your status.

A. Leave with County pay*

- If you choose to use your benefit time, you will continue to receive a County paycheck until your benefit time has been exhausted. Your other benefits will continue as if you were present except the accrual of sick time, which is governed by your contract.
- *Sheriff department injuries with 207-C status have different benefits rules. Contact your department for details.

B. Leave without County pay/Direct pay by the insurance carrier

- If you choose leave without County pay, your other benefits, such as retirement benefits and insurances such as life or disability policies etc., could be affected.
- If you carry health and/or dental policies through the County, you will still be responsible for your portion of the premium (what normally is deducted from your paycheck). You will be billed for this portion. Non-payment will result in cancellation of your health and/or dental policies.
- Once you are on direct pay by the insurance carrier, you will only be reinstated to payroll when you physically return to work.
- By law, you cannot accept County pay and pay from the insurance carrier for the same period – this is fraud. If you receive both pays, contact the County payroll office within one business day (253-1481 or 253-1323).

4. Returning To Work

- You must tell your supervisor about your ability to return to work and any restriction as soon as your provider indicates.
- You must submit a provider's note releasing you to work before you return to work.
- If you are scheduled to appear at a Workers' Compensation Board hearing or have continuing related provider appointments, you must use your own leave time. This time is generally not restorable.
- The insurance carrier may restore some of your benefit time used while on leave with County pay. The restoration is determined at the final Workers' Compensation Board hearing, and may take a year or longer.
- Holidays and floating holidays will not be restored.
- Your payroll clerk will notify you when any benefit time has been restored.

CAYUGA COUNTY
EMPLOYEE REPORT OF WORK RELATED INJURY/ILLNESS
(Employee: fill out within 48 hours of injury/illness and submit to Supervisor)
(PRINT or TYPE)

1. Employee Name: _____ Date of Birth: _____
Home address: _____
Social Security Number: _____ Home phone: _____ Work phone: _____
Gender: Male Female

2. Date of Injury: _____ Time of Injury: _____ Were you on duty at the time of the injury? YES NO
What were your scheduled work hours on the date of the injury? _____
Who was your Supervisor at the time of injury? _____
Did they see it happen? YES NO Did you tell them? YES NO Date: _____ Time: _____
Did anyone else see it happen? YES NO Names: _____

3. Where were you when the injury happened (resident room, garage, etc)? [Include street address if not on a County property]: _____

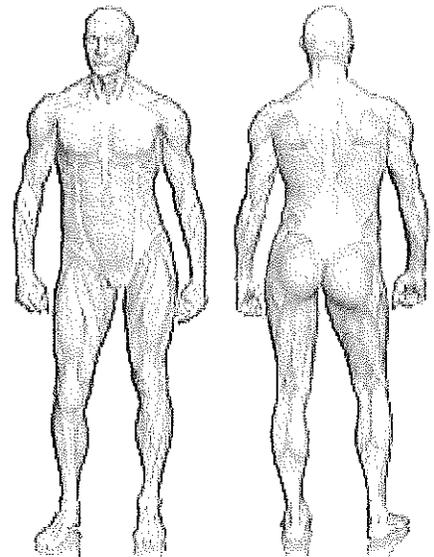
What were you doing when it happened? _____

How did it happen? _____

What was the injury? _____

Was the injury visible? YES NO (Describe) _____

CIRCLE PART(S) OF BODY AFFECTED:



4. Did you leave work on the injury date? YES NO Time: _____
Did you get medical care for the injury? YES NO Date: _____
Where? On Site Doctor's Office Clinic/Urgent Care
 Emergency Room Hospitalized over 24 hours
By whom? Name of Provider: _____
Address of Provider: _____
Phone Number of Provider: _____

*** (Attach Provider note or discharge paper indicating diagnosis)***

- Did you return to work (same day) after getting medical care? YES NO Time: _____
5. Did you miss any work due to this injury? YES NO If time lost was for medical care only, check
 If time lost beyond medical care, first date missed was? _____ ***(Doctor's note required)
6. Have you had a similar injury (on or off job) before? YES NO Date of previous injury: _____
 Do you have any other injuries reported at Cayuga County? YES NO List and describe them: _____

Do you have any existing disabilities or medical restrictions? (Heart condition, diabetes, back problem, etc.)
YES NO Explain: _____

- Are you currently also employed anywhere else? YES NO Where: _____
7. Was the injury due to use or operation of a motor vehicle? YES NO
 Who owned the vehicle? Employee County Other/Unknown
8. What could be done differently to prevent an accident like this from happening again? _____

Please attach additional sheets if necessary for any further explanation

NOTICES:

- Please tell all doctors and hospitals to send all medical reports and bills directly to our carrier.
 New York State Municipal Workers Compensation Alliance
 333 Earle Ovington Blvd., Suite 505
 Uniondale, NY 11553-3624
 (866) 697-6922 (phone); (516) 227-2352 (fax).
- The employee has free choice of provider as long as the provider is approved by the Worker's Compensation Board. The provider must submit medical reports in accordance with the Worker's Compensation Law to the N.Y.S. Municipal Workers' Compensation Alliance. The provider may not submit bills to collect fees from the employee. The County has the right to have the employee examined by a provider of their choice at a time/place reasonable to the employee. Workers' compensation benefits will not be paid without medical proof of disability.
- Any person who knowingly and with intent to defraud any insurance company, or other person who files an application for insurance, or statement of claim containing any materially false information, or conceals information for the purpose of misleading, concerning any fact material thereto, commits a fraudulent insurance act, which is a crime punishable by civil and criminal penalties, including jail.
- If you need more information about workers' compensation in the State of New York, visit: www.wcb.state.ny.us

DECLARATIONS:

- I understand that my signature below means that I am applying for Worker's Compensation benefits pursuant to law.
- I have not made false claims or statements or concealed any material facts in order to receive benefits.
- I authorize providers and other custodians of records to release any medical records relevant to this claim to the workers' compensation insurer, employer, claims administrator and workers' compensation board.
- I hereby affirm under the penalties of perjury that the information contained in this report is true and complete.

Signature: _____ Date: _____

Submit this report to your Supervisor within 48 hours of your injury/illness

Supervisor: send this report (original) together with your Supervisors Report to:
Cayuga County Treasurer, Attn: Payroll
160 Genesee Street, 5th Floor, Auburn, NY 13021
315-253-1481 or 315-253-1323(phone) 315-253-1369 (fax)
payroll@cayugacounty.us

CAYUGA COUNTY

INFORMATION (SUPERVISOR) FOR WORK RELATED INJURY/ILLNESS

1. When Notified of an Employee Injury

- Make sure it is safe for you to reach the injured employee.
- Request Emergency Medical help (911), if necessary.
- Address any immediate safety issues to prevent further injuries.
- Have the employee seek non-emergency medical treatment, if necessary.
- Give the employee a copy of the “Information (Employee) for Work Related Injury/Illness” before they leave for medical care as it contains information on our workers’ compensation insurance that the provider will need.
- Have the employee complete the Cayuga County “Employee Report of Work Related Injury/Illness”.

2. After Injured Employee is cared for

- Have any witnesses complete the “Statement of Employee of Injury/Illness”.
- Complete the “Supervisor Report of Employee Injury/Illness” and submit to department head.
- Send all original reports to the Payroll Office within 48 hours of the injury (no claim can be started without the reports):
 1. Employee Report of Work Related Injury/Illness
 2. Supervisor Report of Employee Injury/Illness
 3. Witness Statement of Employee of Injury/Illness, if any

3. Out Of Work Employee

- Employee must submit a provider’s note taking them out of work.
- Employee must submit a provider’s note releasing them to work before you allow them to return to work.

Department Payroll:

A MSD form needs to be completed and sent to Human Resources & Civil Service for any time lost due to job-related injury. Check the “On Workers’ Compensation” box. In “Remarks”, indicate whether they are being paid using benefit time or if they are unpaid by the County

A MSD form will need to be completed upon the employee’s reinstatement to work as well.

Complete and submit a MSD form each time an employee goes back out on workers’ compensation or is reinstated.

Contact Human Resources & Civil Service (253-1284) if you need additional help with this form.

County Payroll Office:

Cayuga County Treasurer, Attn: Payroll
160 Genesee St, 5th Floor
Auburn, NY 13021
Phone: (315) 253-1481 / (315) 253-1323
Fax: (315) 253-1369
Email: payroll@cayugacounty.us

CAYUGA COUNTY
SUPERVISOR INVESTIGATION REPORT OF EMPLOYEE INJURY/ILLNESS
(PRINT or TYPE)

1. Employee Name: _____ Injury Date: _____ Time of Injury: _____

Specific Location of Incident: _____

2. Did you see it happen? YES NO When were you notified? Date: _____ Time: _____

Did anyone else see it happen? YES NO (Please attach witness statements)

Names: _____

Non-employee involved? YES NO (resident, inmate, citizen) Name: _____

Equipment involved? YES NO (hoyer lift, step ladder, etc): _____

3. Picture(s) of injury or incident scene taken? YES NO (attach copies)

4. Investigation of Incident:

5. Outcome/Recommendations for Corrective Action Plan: (repair equipment, staff education, policy/procedure revision etc.)

Please use back or attach additional sheets if necessary for any further explanation.

Supervisor Name: _____ **Signature:** _____ **Work #:** _____

6. Did employee miss any work due to this injury? YES NO First date missed: _____

Was employee paid for a full day on the day injured? YES NO

Normal Work Week: Mon Tues Wed Thus Fri Sat Sun Other/Rotation: _____

7. Any Additional Outcome/Recommendations as follow-up to incident:

Dept Head/Designee: _____ **Signature:** _____ **Date:** _____

Sheriff Office Only: 207-C? YES NO Date: _____ Init _____

Send this report (original) with your Employee's Report to:

Cayuga County Treasurer, Attn: Payroll
160 Genesee St, 5th Floor, Auburn, NY 13021

315-253-1481 (phone) 315-253-1369 (fax)
payroll@cayugacounty.us

Ver. 5/16/11

Attachment C

Report of Motor Vehicle Accident / NYMIR Automobile Accident Guide

(Use when an accident or injury involves a motor vehicle)

FOLD ← → HERE

New York State Department of Motor Vehicles
REPORT OF MOTOR VEHICLE ACCIDENT
www.dmv.ny.gov

Use only for accidents that happen in New York State

BEFORE COMPLETING THIS FORM, READ THE INSTRUCTIONS IN SECTION A ON PAGE 2

DO NOT FORGET ACCIDENT DATE

Page of RUSH - DRIVER OF VEHICLE 1 - LICENSE SUSPENDED FOR FAILURE TO REPORT

Accident Date (Month, Day, Year), Day of Week, Time (AM/PM), Number of Vehicles, Number Injured, Number Killed, Did police investigate accident at scene? (Yes/No), If "Yes", Name of Police Agency or Precinct & Accident Number

DRIVER OF VEHICLE 1 [] VEHICLE 2 [] PEDESTRIAN [] BICYCLIST [] OTHER PEDESTRIAN

DRIVER SECTION: Driver License ID Number, State of License, Driver Name, Address, City or Town, State, Zip Code, Date of Birth, Sex, Number of People in Vehicle, Public Property Damaged

REGISTRANT SECTION: Name, Date of Birth, Sex, Address, City or Town, State, Zip Code, Plate Number, State of Reg., Vehicle Year & Make, Vehicle Type, Ins. Code

Estimated Cost of Property Damage - Vehicle 1 and Vehicle 2 (options: \$1,001-\$1,500, \$1,501-\$2,500, Over \$2,500)

VEHICLE DAMAGE SECTION: Describe damage to vehicle 1, ACCIDENT DIAGRAM (9 diagrams), Describe damage to vehicle 2

ACCIDENT LOCATION SECTION: Place Where Accident Occurred in New York State: County, Road, Intersecting street, How did the accident happen?

ALL INVOLVED SECTION: Table with columns for Names of All Persons Involved, 8. Which Veh. Occupied, 9. Position in/on Vehicle, 10. Safety Equip. Used, 12. Age, 13. Sex, 16. Injury (A, B, C), Describe Injuries, If Deceased, Enter Date of Death

INSURANCE SECTION: Identify Damaged Property Other Than Vehicle(s), Name of Insurance Company, Name and Address of Policy Holder, VIN, Policy Number, Policy Period, Name and Address of Permit Holder

Date, Print Name of Driver (or Representative*) of Vehicle 1, Signature of Driver (or Representative*) of Vehicle 1

* A representative may sign for the driver if the driver is unable to sign because of injury or death. If you are signing as the driver's representative, check the box that describes why the driver cannot sign. [] Injury [] Death. An accident report is not considered complete and filed unless it is signed, and if not signed may result in the suspension of your driver's license.

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SECTION A

You must report within 10 days any accident occurring in New York State causing a fatality, personal injury or damage over \$1,000 to the property of any one person. Failure to do so within 10 days is a misdemeanor. Your license and/or registration may be suspended until a report is filed. Check the "RUSH" box at the top of page 1 if your license is suspended for failure to report this accident on time. You must fill in all information requested on the report.

Then fill in the boxes numbered 1-7 and 23-30 in the right margin on page 1 by entering the number of the item from Section B that best describes the circumstances of the accident. If a question does not apply, enter a dash ("-"). If you do not know an answer, enter an "X".

INSTRUCTIONS - PLEASE PRINT OR TYPE ALL INFORMATION - USE BLACK INK
* First — fold along this shaded, dotted line.

* Don't fold internet form. Instead, place page 2 over page 1, with the arrows on page 2 pointing to the boxes on the right edge of page 1.

VEHICLE INVOLVEMENT - If you were in an accident involving:

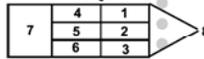
- **two-cars**, enter your information in the VEHICLE 1 section and the other driver's information in the VEHICLE 2 section.
- **a pedestrian, bicyclist or other pedestrian** (a person using a non-motorized conveyance such as in-line skates, skateboard, sled, etc.), enter the information in the "Driver" spaces provided for Vehicle 2, and check the PEDESTRIAN, BICYCLIST or OTHER PEDESTRIAN box.
- **a vehicle other than a motor vehicle** (such as a snowmobile, mini-bike, aircycle, all-terrain vehicle, trail bike, or other non-motor vehicle), enter the driver, registrant and vehicle information in the space provided for VEHICLE 2.
- **an unoccupied vehicle**, enter all available information. Be sure to enter the correct vehicle Plate Number and Vehicle Type in the VEHICLE 2 block.
- **more than two vehicles**, fill out additional accident reports. On these reports, place the information for the third vehicle in the space marked VEHICLE 1 and mark it # 3. Use the space marked VEHICLE 2 for the fourth vehicle, and mark it # 4 and so on. Additional forms are available at any Motor Vehicles office or from the DMV website: www.dmv.ny.gov.

- 1 DRIVER** - Enter the information for each driver EXACTLY as it appears on his/her driver license.
- 2 REGISTRANT** - Enter registrant information EXACTLY as it appears on the registration of each vehicle involved in the accident.
- 3 VEHICLE DAMAGE** - Indicate if the accident exceeds the \$1,000 threshold for property damage to any one vehicle or property caused by the accident, and describe the vehicle damage.
- 4 ACCIDENT LOCATION** - Enter the county, locality and street(s) where the accident occurred. Check the box if there is an intersecting street. If available, identify a **permanent landmark** nearby, such as a business, school, shopping mall, parking lot, water tower, railroad, mountain or cell tower.
- 5 ALL INVOLVED** - List the names of all persons involved in the accident, and provide the date of death if anyone was killed in, or as a result of, the accident. If more than four people are involved, complete another report. In the ALL INVOLVED section of that report, provide the required information for everyone else involved in the accident. Enter the following codes in the appropriate columns:

WHICH VEHICLE OCCUPIED (Column 8) - Enter the appropriate number or letter.

1. Vehicle 1 2. Vehicle 2 B. Bicyclist P. Pedestrian O. Other Pedestrian

POSITION IN/ON VEHICLE (Column 9) - Enter the number from this diagram which corresponds to each person's position.

1. Driver 2-7. Passengers 8. Riding/Hanging on Outside
- 

SAFETY EQUIPMENT USED (Column 10)

- | | | | |
|-----------------------------|---|--------------------------|------------------|
| 1. None | 7. Air Bag Deployed | In-Line Skater/Bicyclist | |
| 2. Lap Belt | 8. Air Bag Deployed/Lap Belt | | |
| 3. Shoulder Restraint | 9. Air Bag Deployed/Shoulder Restraint | | C. Helmet Only |
| 4. Lap Belt Restraint | A. Air Bag Deployed/ Lap Belt/Restraint | | D. Helmet/Other |
| 5. Child Restraint Only | B. Air Bag Deployed/Child Restraint | | E. Pads Only |
| 6. Helmet (Motorcycle Only) | O. Other | | F. Stoppers Only |

INJURY (Columns 16A-C) - Check all column(s) that apply and DESCRIBE INJURIES:

- A - Severe lacerations, broken or distorted limbs, skull fracture, crushed chest, internal injuries, unconscious when taken from the accident scene, unable to leave accident scene without assistance.
- B - Lump on head, abrasions, minor lacerations.
- C - Momentary unconsciousness, limping, nausea, hysteria, complaint of pain (no visible injury), whiplash (complaint of neck and head pain).

- 6 INSURANCE** - Enter damage to private property, if any, insurance policy information and VIN. Attach additional reports to page one. Each page of the report must be numbered in the upper left corner. Mark additional sheets #2, #3, etc. Date and sign on the bottom line of each attached report. THE REPORT MUST BE SIGNED BY THE DRIVER OF VEHICLE 1, UNLESS HE OR SHE IS UNABLE TO SIGN BECAUSE HE/SHE IS INJURED OR DECEASED.

Send original to: CRASH RECORDS CENTER
6 EMPIRE STATE PLAZA
PO BOX 2925
ALBANY NY 12220-0925

SECTION B

USE TO COMPLETE

BOXES 1-7 and 23-30 ON PAGE 1

Be sure your answers are marked INSIDE THE BOXES ON PAGE 1

PEDESTRIAN/BICYCLIST/OTHER PEDESTRIAN LOCATION

1. Pedestrian/Bicyclist/Other Pedestrian at Intersection
2. Pedestrian/Bicyclist/Other Pedestrian Not at Intersection

PEDESTRIAN/BICYCLIST/OTHER PEDESTRIAN ACTION

1. Crossing, With Signal
2. Crossing, Against Signal
3. Crossing, No Signal, Marked Crosswalk
4. Crossing, No Signal or Crosswalk
5. Riding/Walking/Skating Along Highway With Traffic
6. Riding/Walking /Skating Along Highway Against Traffic
7. Emerging from in Front of/Behind Parked Vehicle
8. Going to/From Stopped School Bus
9. Getting On/Off Vehicle Other Than School Bus
11. Working in Roadway
12. Playing in Roadway
13. Other Actions in Roadway
14. Not in Roadway

TRAFFIC CONTROL

- | | |
|-------------------------------|--|
| 1. None | 10. RR Crossing Gates |
| 2. Traffic Signal | 11. Stopped School Bus-Red Lights Flashing |
| 3. Stop Sign | 12. Construction Work Area |
| 4. Flashing Light | 13. Maintenance Work Area |
| 5. Yield Sign | 14. Utility Work Area |
| 6. Officer/Guard | 15. Police/Fire Emergency |
| 7. No Passing Zone | 16. School Zone |
| 8. RR Crossing Sign | 20. Other |
| 9. RR Crossing Flashing Light | |

LIGHT CONDITIONS

- | | | |
|-------------|----------------------|------------------------|
| 1. Daylight | 3. Dusk | 5. Dark-Road Unlighted |
| 2. Dawn | 4. Dark-Road Lighted | |

ROADWAY CHARACTER

- | | |
|--------------------------|-----------------------|
| 1. Straight and Level | 4. Curve and Level |
| 2. Straight and Grade | 5. Curve and Grade |
| 3. Straight at Hillcrest | 6. Curve at Hillcrest |

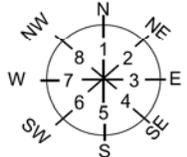
ROADWAY SURFACE CONDITION

- | | | | |
|--------|-------------|------------|----------|
| 1. Dry | 3. Muddy | 5. Slush | 0. Other |
| 2. Wet | 4. Snow/Ice | 6. Flooded | |

WEATHER

- | | |
|-----------|-----------------------------|
| 2. Cloudy | 5. Sleet/Hail/Freezing Rain |
| 3. Rain | 6. Fog/Smog/Smoke |
| 4. Snow | 0. Other |
| 1. Clear | |

DIRECTION OF TRAVEL



1. North	5. South
2. Northeast	6. Southwest
3. East	7. West
4. Southeast	8. Northwest

Veh. 1, 23
Veh. 2, 24

PRE-ACCIDENT VEHICLE ACTION

- | | |
|-----------------------------|--------------------------------|
| 1. Going Straight Ahead | 11. Avoiding Object in Roadway |
| 2. Making Right Turn | 12. Changing Lanes |
| 3. Making Left Turn | 13. Passing |
| 4. Making U Turn | 14. Merging |
| 5. Starting from Parking | 15. Backing |
| 6. Starting in Traffic | 16. Making Right Turn on Red |
| 7. Slowing or Stopping | 17. Making Left Turn on Red |
| 8. Stopped in Traffic | 18. Police Pursuit |
| 9. Entering Parked Position | 20. Other |
| 10. Parked | |
- Veh. 1, 25
Veh. 2, 26

LOCATION OF FIRST EVENT

1. On Roadway
2. Off Roadway

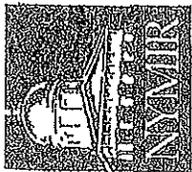
TYPE OF ACCIDENT

- COLLISION WITH**
- | | |
|------------------------|------------------------------|
| 1. Other Motor Vehicle | 6. In-Line Skater |
| 2. Pedestrian | 7. Deer |
| 3. Bicyclist | 8. Other Pedestrian |
| 4. Animal | 10. Other Object (Not Fixed) |
| 5. Railroad Train | |
- COLLISION WITH FIXED OBJECT**
- | | |
|--------------------------------|-------------------------------------|
| 11. Light Support/Utility Pole | 21. Median - Not At End |
| 12. Guide Rail - Not At End | 22. Snow Embankment |
| 13. Crash Cushion | 23. Earth Embankment/Rock Cut/Ditch |
| 14. Sign Post | 24. Fire hydrant |
| 15. Tree | 25. Guide Rail - End |
| 16. Building/Wall | 26. Median - End |
| 17. Curbing | 27. Barrier |
| 18. Fence | 30. Other Fixed Object |
| 19. Bridge Structure | |
| 20. Culvert/Head Wall | |
- First Event, 28
Veh. 1, 29
Second Event
Veh. 2, 30

NO COLLISION

- | | |
|--------------------|--------------------------|
| 31. Overturned | 33. Submersion |
| 32. Fire/Explosion | 34. Ran Off Roadway Only |
| | 40. Other |

NYMIR AUTOMOBILE ACCIDENT GUIDE



Accidents, by their nature are frightening experiences. Keep your composure. Included here are suggestions that will help you control the situation.

Protect the Scene-If possible, move onto the shoulder or side of the roadway. Turn on emergency flashers. As soon as possible, put out warning devices or flares.

Get Help-Use the vehicle's telephone communications equipment or ask someone to summon police. If there are injuries-get medical assistance.

Stay Calm-Don't engage in arguments with the other drivers. Don't make statements about the accident except to other municipal employees or the police. When asked questions-give objective answers-don't speculate. Don't offer settlements.

Get Names & Addresses-Obtain the identities of all persons, other vehicle information, name of investigating officer and agency, try to learn where injured parties are being taken.

Look for Witnesses-Such as other motorists or pedestrians in the vicinity.

Render First Aid-If you are qualified and able to do so. Don't move injured parties unless an immediate hazard is noted, such as chance of fire or water submersion.

Check the Scene Before you Leave-Make sure you have all information before you leave.

Complete Reports-Report the accident to your supervisor in accordance with municipal policy. Complete an MV-104.

Report Accident to the Broker/NYMIR-as soon as possible let Eastern Shore Associates know about the accident. Send all official reports (MV104)

CALL - 911

Report all accidents to your immediate Supervisor who shall then report the accident to the Clerk of the Legislature, Chairman and County Administrator.

New York State Law states that a MV-104 form must be filed out when an accident has occurred, (form Attached)

All forms are to be filed out and brought to the Clerk of the Legislature Office ASAP.

Clerk of the Legislature
253-1498
Chairman's Office
253-1273

Please add your supervisor's Name and phone number

Please replace forms, all Department Heads have copies of forms.

All County vehicles must have a copy Of these forms kept in the glove box.

ESA Eastern Shore Associates

I N S U R A N C E

PO Box 480

101 Cayuga Street

Fulton, New York 13069

315-598-6000/1-800-836-3324

315-598-1183 fax#

Cayuga County

Telephone Claims Reporting
Bridgette Seguin
1-800-836-3324

or

Fax 315-598-1183

or

bseguin@esainsurance.com

ESA Claims Representative will complete the notice of loss by asking you the necessary questions. Please have this completed Driver's Report of Accident available.

