TCWC-2 (REV 2/02)
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 INJURY AND 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 ANY QUESTIONS, PLEASE CONTACT AMY POFF AT 687-8205 

PLEASE RETURN TO YOUR SUPERVISOR WITHIN 48 HOURS:  

SUPERVISOR PLEASE RETURN TO:  
TIOGA COUNTY SELF-INSURANCE PLAN 
56 MAIN STREET 
OWEGO, NY 13827