SUFFOLK COUNTY WATER AUTHORITY
WORKERS' COMPENSATION

INJURY AND MEDICAL REPORTING PROCEDURE

If you are involved in an on-the-job injury, you must:

- Report the accident to your immediate supervisor.
- Complete the attached 24-Hour Accident Report as soon as possible.

If you require medical attention as the result of an on-the-job injury, you must:

- File a 24-Hour Accident Report as required above.
- Advise your physician that your injury is work related **and** provide the insurance information below.
- Have your physician complete the attached *Physical Condition and Restrictions Report* addressing your degree of disability **and** outlining your ability to work either full or modified duties.
- All medical documentation must be returned to Michelle Ruiz or Claire Walsh in HR as soon as possible.

If your on-the-job injury results in lost time from work, you must:

- File a 24-Hour Accident Report as required above.
- Get examined by a physician and return the attached Physical Condition and Restrictions Report
- For continued lost time, a Monthly Medical Report must be submitted to Michelle Ruiz in HR **every four weeks** which addresses your degree of disability **and** work ability.

SCWA offers an extensive Return to Work/Modified Duty Program.

When returning to work on light/modified duty, you must:

- Provide a completed SCWA Physical Conditions and Restrictions Report **prior** to returning to work and every four weeks thereafter. All medical **must include** a specific list of work restrictions.
- If restrictions are not included in the medical report, you will not be permitted to return to work.

For injuries occurring on or after *April 1, 2026,* our new insurance company is:

PERMA
PO Box 12250
Albany, NY 12212
Phone: 888-737-6269
Fax: 877-737-6232

Revised April 2026

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WC EXCUSED TIME FOR MEDICAL TREATMENT

When utilizing Workers' Compensation "Excused Time" for a medical appointment, therapy session etc., you are required to provide medical documentation substantiating each absence prior to the close of the payroll period.

A "WC Excused Time" request form must be attached to the medical documentation which includes the following:

- Date and time of the appointment.
- Date of injury you are being treated for.
- Diagnosis with notation that the treatment is due *to* an on-the-job injury.
- A note on the treating physician's letterhead or office stamp providing their address and phone number.

Failure to provide the necessary request form and medical documentation will result in your accruals being charged.

In accordance with the Collective Bargaining Agreement, Article XV, Section 8:
"The Authority will not permit portions of a day to be charged as Excused Time for medical treatment except if the medical treatment is scheduled during the last two hours of a normal workday and the medical treatment is not available at any other time. In addition, the Authority, upon application to the Human Resources Department, may permit employees *to* charge portions of a day for medical treatment. Requests shall not be unreasonably denied."

Note: The Authority will permit employees to use excused time to attend Independent Medical Exams (IMEs) as requested by the Authority or its insurance carrier and to attend Workers' Compensation Board hearings as required by NYS.
Excused time as set forth above will be permitted only upon submission of a hearing notice and/or IME appointment letter.

Should you have any questions or concerns, please contact **Michelle Ruiz or Claire Walsh in HR**

Michelle Ruiz:
Email: michelle.ruiz@scwa.com
Phone: 631-563-0392
Fax: 631-563-0300

Claire Walsh:
Email: claire.walsh@scwa.com
Phone: 631-563-0310
Fax: 631-563-0300

Incident Report

This form must be completed by the employee and submitted to the employee's direct supervisor.Supervisors to complete and submit in section 7 of the E-form

Employee Information

Employee's Name: | **SCWA ID #:** | **Phone Number:**

Supervisor's Name: | **Employee's Job Title:**

Employee's home address: | **I am:** ☐Right-Handed ☐Left-Handed

Employee's Email:

Incident Information

Date of Injury: ___/___/_____
Time of Injury: ___:___AM PM

Date Reported: ___/___/_____
Time Reported: __:___AM PM

Reported to a supervisor within one shift?:
☐YES **Reported to:** _____
☐NO

Weather Conditions:

☐Rain ☐Wind ☐Snow ☐Fog ☐Storm ☐Temperature ☐No notable weather conditions ☐Other:

Temperature (in °F): _____

Address of the Incident Site:
Street/Building _____
City _____ Zip Code _____

☐Outdoors/Yard ☐Pump Station
☐Indoors/Building ☐Residential/Excavation/Service

Description of the Injury/Incident Severity Characteristics

PPE worn at time of incident (*check all that apply*):

☐Hard Hat ☐Gloves ☐Safety Shoes ☐Rubber Boots ☐Glasses ☐Goggles ☐Respirator ☐Vest ☐Hearing Protection ☐Insect Repellent

- ↓ ☐Cut resistant, ☐Chem gloves, ☐Electrical, ☐Nitrile/Latex, ☐Other: _____
- ↓ ☐Dust Mask, ☐N95 (or equal), ☐Half Face, ☐Full Face
- ↓ ☐Ear Plugs, ☐Earmuffs
- ↓ ☐Bug Spray, ☐Permethrin

Body Part Injured: (*check all that apply*):

☐Head ↓ ☐ Left side ☐ Right side	☐Eye ↓ ☐ Left eye ☐ Right eye	☐Face ↓ ☐ Left side ☐ Right side	☐Mouth ↓ ☐ Left side ☐ Right side	☐Neck ↓ ☐ Left side ☐ Right side	☐Shoulder ↓ ☐ Left ☐ Right
☐Arm ↓ ☐ Left ☐ Right	☐Elbow ↓ ☐ Left ☐ Right	☐Forearm ↓ ☐ Left ☐ Right	☐Wrist ↓ ☐ Left ☐ Right	☐Hand ↓ ☐ Left ☐ Right	☐Fingers ↓ ☐ Right ↓ ☐ Thumb ☐ Index ☐ Middle ☐ Ring ☐ Pinky; ☐ Left ↓ ☐ Thumb ☐ Index ☐ Middle ☐ Ring ☐ Pinky
☐Back ↓ ☐ Right ↓ ☐ Upper ☐ Mid ☐ Lower; ☐ Left ↓ ☐ Upper ☐ Mid ☐ Lower	☐Abdomen ↓ ☐ Left ☐ Right	☐Hip ↓ ☐ Left ☐ Right	☐Thigh ↓ ☐ Left ☐ Right	☐Knee ↓ ☐ Left ☐ Right	☐Lower Leg ↓ ☐ Left ☐ Right
☐Ankle ↓ ☐ Left ☐ Right	☐Foot ↓ ☐ Left ☐ Right	☐Toes ↓ ☐ Right ↓ ☐ Big toe ☐ 2nd toe ☐ 3rd toe ☐ 4th toe ☐ Pinky toe; ☐ Left ↓ ☐ Big toe ☐ 2nd toe ☐ 3rd toe ☐ 4th toe ☐ Pinky toe		☐Other: Please explain	

Injury Cause (*check all that apply*):

☐Body Movement ☐Burn ☐Chemical ☐Chronic ☐Environmental ☐Foreign Object ☐Hearing Loss
☐Insect Bite ☐Material Handling ☐Motor Vehicle ☐Object Handled ☐Occupational ☐Personal Health ☐Slip/Trip/Fall
☐Sprain/Strain ☐Strike Against ☐Struck By ☐Trench Collapse ☐Other: _____

Injury Type (*check all that apply*):

☐Insect Bite ☐Bruise/Swelling ☐Cut/Laceration ☐Burn ☐Head Injury ☐Hearing Loss ☐Electric Shock ☐Internal Damage
☐Poison Ivy ☐Sprain/Strain ☐Dislocation ☐Fracture ☐Abrasion/Scrape ☐Occupational ☐Other: _____

Thoroughly describe what caused the incident to happen:	**Thoroughly describe what factors led to the incident:**

Attachments: Please submit any applicable attachments to the supervisor to submit on the E-form (ex. photos, MV-104, supplemental documents, etc.)

Name(s) of Witness(es): _____

Did you finish your entire shift on the day of the incident? ☐YES ☐NO

Have you ever been treated for a similar injury or condition? ☐YES ☐NO *If yes*, **Approx. Date:** ___/____

Medical Treatment

Are you currently seeking treatment:
☐NONE ☐Plan to receive treatment
☐Hospital ☐Walk-In Clinic ☐Doctor's Office

Doctor's / Facility Name:

Treatment Center Address:

Street _____ City _____ Zip Code_____

Required Signature

By submitting this form, the employee agrees that this is an accurate representation of the accident. Please sign with your name and employee ID number below. By submitting this form, the employee who is represented by Local 393, authorizes the employer (SCWA) to release a copy of this form to Local 393. If the employee does not wish to release this information to Local 393, the employee must indicate it on the written form.

Employee's Signature: _____

Date of Submittal: ___/___/____

Employee ID Number: _____

SUFFOLK COUNTY WATER AUTHORITY

REQUEST FOR USE OF EXCUSED WORKERS' COMPENSATION TIME

In accordance with CBA Article XV, Section 8

*The Authority will not permit portions of a day to be charged as excused time for medical treatment except if the medical treatment is scheduled during the **last two hours** of a normal workday and the medical treatment is not available at any other time. In addition, the Authority, upon application to the Human Resources Department, may permit employees to charge portions of a day for medical treatment. Requests shall not be unreasonably denied.*

Name: _____ Employee No.: _____

WC Date of Injury/Accident: _____

Type of Excused Time Requested: (Circle one)

MD Visit *WCB Hearing* *Physical Therapy* *IME*

Date of Requested Excused time: _____ Appointment time: _____

Leaving work time: _____ Amount of Time Requested: _____ (max. 2 hours)

Employees must have his/her Supervisor sign this form and submit it to HR along with all supporting medical documentation no later than the following Tuesday of each week (he employees accruals may be charged in the absence of the required documentation).

I certify that my absence from work on the above date/time was due to the reason(s) stated. I understand that providing false or misleading information will result in disciplinary action.

I state that the above information is correct, and all supporting documentation will be submitted.

_____ _____

Employee's Signature/Date Supervisor's Signature/Date

IN ORDER FOR MEDICAL EVIDENCE TO BE DEEMED ACCEPTABLE, IT MUST INCLUDE:

1. DATE AND TIME OF THE APPOINTMENT ON DOCTOR'S STATIONERY
2. DATE OF WORKERS' COMPENSATION INJURY THAT THE EMPLOYEE IS BEING TREATED FOR AND THAT TREATMENT IS DUE TO THAT JOB RELATED INJURY
3. THE TREATING PHYSICIAN MUST SIGN THE MEDICAL DOCUMENTATION OR PROVIDE THEIR STAMP **(THE TREATING PHYSICIAN SIGNING ONLY THE WDA FORM IS NOT ACCEPTED)**

IN THE CASE OF A WORKERS' COMPENSATION HEARING, THE EMPLOYEE SHOULD ASK THE CLERK AT THE HEARING DESK TO TIME STAMP THE HEARING NOTICE UPON EXIT FROM THE HEARING.

IF ACCEPTABLE DOCUMENTATION IS NOT PROVIDED, THE EMPLOYEE'S ACCRUALS WILL BE CHARGED. PLEASE RETURN THIS FORM TO MICHELLE RUIZ IN HUMAN RESOURCES UPON COMPLETION.

PHYSICAL CONDITION AND RESTRICTIONS REPORT

Employee: _____ Position: _____ CDL: ☐ Yes ☐ No

Department: _____ Employee number: _____

Date of Injury/Illness: _____ Date of Return to Work: _____

(Examining Physician to complete the following section)

Indicate Employee's Fitness for Duty: As of _____(Date)

☐ Fit for Full Duty ☐ Fit for Restricted duty ☐ Totally Disabled

Physical Restrictions:	**Unrestricted**	**Restricted**	
Ability to Walk	☐	☐	Explain: _____
Ability to Stand	☐	☐	Explain: _____
Ability to Operate Vehicle	☐	☐	Explain: _____
Ability to Operate Commercial Motor vehicle (over 26,00 LBS) in accordance with DOT	☐	☐	Explain: _____
Ability to Work Outdoors	☐	☐	Explain: _____
Ability to Bend Body	☐	☐	Explain: _____
Ability to Crouch	☐	☐	Explain: _____
Ability to Climb Stairs	☐	☐	Explain: _____
Ability to Lift (Indicate any LBS restrictions)	☐	☐	Explain: _____
Other	☐	☐	Explain: _____

Is the employee currently taking any medication that may impair his/her judgement, or the ability to drive or perform their duties (as outlined on the attached job description): ☐ Yes ☐ No

If Yes, explain: _____

Able to write/type: ☐ Yes ☐ No Able to Use Phone: ☐ Yes ☐ No

Physician: _____ Signature: _____ Date: _____

Revised June 2021