CORRECTION DEPARTMENT
CITY OF NEW YORK

INJURY TO INMATE REPORT

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Form: #167R-A
Rev.:01/31/08
Ref.: Dir. #4516R-A

INSTRUCTIONS: Original Report to Security, One copy to Clinic Lock Box, One copy to Inmate Medical File.

Command:	Date:	COD/UOF #:	Injury #:

TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT CLEARLY).

Inmate Name (Last Name, First Name)

Location:	Work:	NYSID #:	Book & Case/Sent #:

Details:

Supervisor Notified (Print Last Name, First Name, Rank, Shield #):	Date:	Time: Hrs.

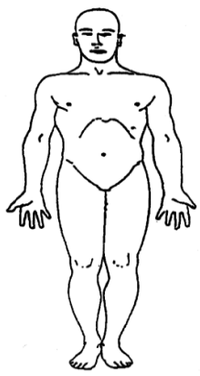
Employee: I ☐ (Did) ☐ (Did Not) Witness This Injury.	Employee Signature:	Rank/Title:	Shield/ID#:

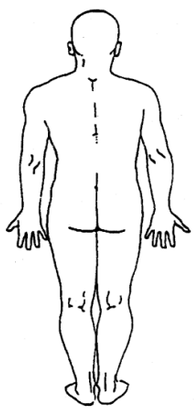
TO BE COMPLETED BY MEDICAL STAFF ONLY - (PLEASE PRINT CLEARLY)

Date of Injury:	Reported for Medical Attention: Date Hrs.	Inmate Refused Medical Attention: ☐ Yes ☐ No	Visible Injuries: ☐ Yes ☐ No

Nature of Injury and Cause (Note-Medical Staff should include only information relevant to the injury):

Medical Staff Must Note Location of Injury:





Treatment:

Treated By/Examined By (Print and Sign Full Name):	Title:

Referrals to Other Medical Services (If Yes, Document Medical Findings): ☐ Yes ☐ No

Treated By/Examined By (Print and Sign Full Name):	Title:

Please Check Disposition:
☐ Return to Housing Area ☐ Work Release _____Days ☐ Light Duty ____ Days ☐ Return to Work Assignment ☐ Re-Exam ____ Days ☐ Refer to Clinic ☐ Return to School

☐ Transfer to Hospital (Indicate Name of Hospital): _____ ☐ Life Threatening Emergency ☐ Routine

☐ Other (Please Specify): _____

Treated By (Print Full Name and Title, Sign Name) Date: Time Hrs.

I certify that the cause of injury as stated herein is to my knowledge true and medical attention was provided.

INMATE SIGNATURE:	B&C/Sentence #:		Date:
WITNESSED BY (Signature):	Rank/Title:	Shield /I.D. #:	Date: