

**Employer's First Report of  
Work-Related Injury/Illness**

A work-related injury or illness must be reported within 10 days (Per Section 110) of the injury/illness or be subject to a penalty. Employers are not required to submit form C-2F to the Workers' Compensation Board if the employer's insurer will be submitting the accident information electronically to the Board on the employer's behalf. If you need assistance completing this form, please contact your insurer for guidance on the best method of reporting work-related accident information. If you submit this form to the Board, please send it to P.O. Box 5205, Binghamton, NY 13902 and provide a copy to your insurer.

**Employee Name** \_\_\_\_\_**WCB Case Number (JCN)** \_\_\_\_\_ **Date of Injury** \_\_\_\_\_**Claim Administrator Claim Number** \_\_\_\_\_**INSURER / CLAIM ADMINISTRATOR INFORMATION****Insurer Name** \_\_\_\_\_ **Insurer ID** \_\_\_\_\_**Name** \_\_\_\_\_**Info/Attn** \_\_\_\_\_**Address** \_\_\_\_\_**City** \_\_\_\_\_ **State** \_\_\_\_\_**Postal Code** \_\_\_\_\_ **Country** \_\_\_\_\_**Claim Admin ID** \_\_\_\_\_**EMPLOYEE INFORMATION****First Name** \_\_\_\_\_ **Middle Name/Initial** \_\_\_\_\_**Last Name** \_\_\_\_\_ **Suffix** \_\_\_\_\_**Mailing Address** \_\_\_\_\_**City** \_\_\_\_\_ **State** \_\_\_\_\_**Postal Code** \_\_\_\_\_ **Country** \_\_\_\_\_**Phone Number** \_\_\_\_\_ **Date of Hire** \_\_\_\_\_**Date of Birth** \_\_\_\_\_ **Gender**  Male  Female  Unknown**Employee SSN** \_\_\_\_\_**Occupation Description** \_\_\_\_\_

**CLAIM INFORMATION**

Time of Injury \_\_\_\_\_ Date Employer Had Knowledge of the Injury \_\_\_\_\_  
Employment Status \_\_\_\_\_ Date Employer Had Knowledge of Date of Disability \_\_\_\_\_  
Estimated Weekly Wage \_\_\_\_\_ Number of Days Worked Per Week \_\_\_\_\_  
Work Week Type  Standard Work Week  Fixed Work Week  Varied Work Week  
Work Days Scheduled  Sun  Mon  Tues  Wed  Thurs  Fri  Sat

**EMPLOYEE INJURY**

Full Wages Paid for Date of Injury  Yes  No Employer Paid Salary in Lieu of Compensation  Yes  No  
Initial Treatment  No Medical Treatment  Minor On-Site Treatment By Employer  Minor Clinic/Hospital Treatment  
 Emergency Evaluation  Hospitalization Greater Than 24 Hours  Future Major Medical/Lost Time Anticipated  
Death Result of Injury  Yes  No  Unknown Date of Death \_\_\_\_\_ Number of Dependents \_\_\_\_\_  
Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc) \_\_\_\_\_  
Part of Body (i.e. left arm, right foot, head, multiple, etc) \_\_\_\_\_  
Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc) \_\_\_\_\_  
Accident/Injury Description (see instructions)

**WORK STATUS**

Initial Date Last Day Worked \_\_\_\_\_ Return To Work Type  Actual  Released  
Initial Date Disability Began \_\_\_\_\_ Physical Restrictions  Yes  No  
Initial Return to Work Date \_\_\_\_\_ Return To Work Same Employer  Yes  No

**ACCIDENT LOCATION AND WITNESSES**

Premises (see instructions)  Employer  Lessee  Other  
Organization Name \_\_\_\_\_  
Street \_\_\_\_\_ State \_\_\_\_\_  
City \_\_\_\_\_ Postal Code \_\_\_\_\_  
County \_\_\_\_\_ Country \_\_\_\_\_  
Location Narrative \_\_\_\_\_

**Witnesses**

**Business Phone Number**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMPLOYER INFORMATION**

Name \_\_\_\_\_ Employer FEIN \_\_\_\_\_

UI Number \_\_\_\_\_ Manual Classification Code \_\_\_\_\_

Industry Code \_\_\_\_\_

Info/Attn \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Physical Addr \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Contact Name \_\_\_\_\_

Contact Business Phone Number \_\_\_\_\_

**INSURED INFORMATION**

Insured Name \_\_\_\_\_ Insured FEIN \_\_\_\_\_

Insured Type  Insured  Self-Insured  Uninsured Insured Location ID \_\_\_\_\_

Policy Number ID \_\_\_\_\_

Policy Effective Date \_\_\_\_\_ Policy Expiration Date \_\_\_\_\_

**An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.**

The above information is true to the best of my knowledge and belief.

If prepared by the employer:

Signature of Person Preparing Form \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Title \_\_\_\_\_ Phone Number \_\_\_\_\_