WORKERS' COMPENSATION BOARD
New York State

EMPLOYER'S REPORT OF WORK-RELATED INJURY/ILLNESS

C-2

State of New York - Workers' Compensation Board

If one of your employees has a work-related injury or illness, you must complete and file this form **within 10 days** of the injury/illness or be subject to a penalty. For additional information on filing this form please refer to Workers' Compensation Law Section 110 at the end of this form. Type or print neatly.

WCB Case Number (if you know it): ______________________ Date of Injury/illness: ______/______/______

Carrier Case Number (if you know it): ______________________ Date of this Report: ______/______/______

A. EMPLOYER INFORMATION

1. Employer: ______________________ 2. Employer FEIN: ______________________

3. Mailing Address: ______________________

4. Location Address (if different): ______________________

5. Phone Number: (______)______________ 6. Nature of Business or Industry Code: ______________________

7. OSHA Case Number (if known): ______________ 8. NY UI Employer Reg Number: ______________

B. INSURANCE CARRIER / SELF-INSURED EMPLOYER

If individually self-insured, enter your Board W Number and skip to Section C.

1.Board W Number: **W** ______________ 2. Carrier/Group Name: ______________________

3. Policy Number: ______________ Policy Period: From: ____/____/____ To: ____/____/____

4. If Carrier Unknown, Insurance Agent Name: ______________________ 5. Phone Number: (______)______________

C. EMPLOYEE'S PERSONAL INFORMATION

1. Name: ______________________ (First / MI / Last) 2. Date of Birth: ____/____/____

3. Mailing Address: ______________________

4. Social Security Number: ______________ 5. Contact Phone Number: (______)______________ 6. Gender: ☐ Male ☐ Female

D. EMPLOYEE'S INJURY OR ILLNESS

1. Time of day employee began work on date of injury: __________ ☐ AM ☐ PM 2. Time of injury: __________ ☐ AM ☐ PM

3. Has the employee given you notice of injury/illness? ☐ Yes ☐ No

If yes, notice was given to: ______________________ ☐ orally ☐ in writing Date notice provided: ____/____/____

If available, attach a copy of the employee's written notice and medical notes, and the employer's incident report.

4. Have you given the employee a Claimant Information Packet? ☐ Yes ☐ No If yes, give date: ____/____/____

5. Where did the injury/illness happen (e.g., 1 Main St., Pottersville, at the front door): ______________________

____

6. Was this location where the employee normally worked? ☐ Yes ☐ No If no, why was the employee there? ______________

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7. Employee's supervisor: ______________________ 8. Did supervisor see injury happen? ☐ Yes ☐ No ☐ Unknown

9. Did anyone else see the injury happen? ☐ Yes ☐ No ☐ Unknown If yes, give name(s): ______________________

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10. What was the employee doing when he/she was injured or became ill? (e.g., unloading a truck, stocking a shelf, typing annual report)

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THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE
WITH DISABILITIES WITHOUT DISCRIMINATION

D. EMPLOYEE'S INJURY OR ILLNESS *continued*

11. How did the injury/illness occur? (e.g., the employee tripped over a pipe and fell on the floor) ______________________________

12. Explain fully the nature of the employee's injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): ______________________________

13. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what was it? ______________________________

14. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No

    If yes, ☐ employee's vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): ______________________________

    If employer's vehicle was involved, give name and address of your motor vehicle insurance carrier: ______________________________

15. Did the injury/illness result in the employee's death? ☐ Yes ☐ No If yes, what was the date of death? _____/_____/_____

    Name and address of the nearest relative: ______________________________

E. MEDICAL TREATMENT

1. What was the date of the employee's first treatment? _____/_____/_____ ☐ None received ☐ Unknown
2. Where did the employee receive first medical treatment for this injury/illness? ☐ On site ☐ Doctor's office ☐ Emergency Room ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours ☐ Unknown

   Who treated the employee and where? ______________________________
3. Is the employee still being treated for this injury/illness? ☐ Yes ☐ No ☐ Unknown If yes, name and address of treating doctor(s): ______________________________
4. To your knowledge, did the employee have another work-related injury to the same body part or a similar illness while working for you?

   ☐ Yes ☐ No If yes, name the doctor(s) who treated the previous injuries/illnesses (if known): ______________________________

F. RETURN TO WORK

1. Did the employee stop work because of his/her injury/illness? ☐ Yes ☐ No If yes, on what date? _____/_____/_____
2. Has the employee returned to work? ☐ Yes ☐ No

   If yes, on what date? _____/_____/_____ ☐ regular duty ☐ limited duty
3. If the employee has returned to limited duty, what are his/her average gross earnings per week? ______________________________

EMPLOYEE'S NAME: ____ **DATE OF INJURY/ILLNESS:**_____/_____/_____
First MI Last

G. EMPLOYEE'S WORK INFORMATION on the date of the injury or illness

1. Date the employee was hired: _____/_____/_____

2. What was the employee's job title? ________________________________

3. What types of activities did the employee normally perform at work? (Attach job description if available.)________________________

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H. EMPLOYEE'S PAYROLL INFORMATION on the date of the injury or illness

1. Employee's gross pay in an average week was: $ ______________

2. Did the employee receive lodging or tips in addition to pay? ☐ Yes ☐ No If yes, describe: ______________________

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3. Employee's job was (check one): ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other:______________

4. Which days of the week did the employee usually work? ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.

5. Was the employee paid for a full day on the day of the injury/illness? ☐ Yes ☐ No

6. Did you continue to pay the employee after the injury/illness (e.g., sick leave, vacation, disability, regular salary)? ☐ Yes ☐ No

I. ADDITIONAL INFORMATION

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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: (_____)__________

If prepared by a Third Party on Behalf of the Employer:

Signature of Person Preparing Form: ______________________________ Date: _____/_____/_____

Print Name: ______________________ Title: ______________________ Phone Number: (_____)__________

Company Name and Address:____

Name & Phone Number of Person Who Provided Information Necessary to Prepare This Form: ______________________