



Workers' Compensation Claim Form

Record ID _____

Entered By: _____

Reviewed By: _____

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: _____ 2. Date of Birth: _____
First MI Last

3. Mailing Address: _____
Street Address City State Zip

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: hh mm : AM PM 2. Time of injury: hh mm : 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?

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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EMPLOYEE'S NAME _____

DATE OF INJURY/ILLNESS: _____

D. EMPLOYEE'S INJURY OR ILLNESS *continued*

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)

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 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):



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EMPLOYEE'S NAME _____ DATE OF INJURY/ILLNES _____
First MI Last

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/illness (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? _____

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.)

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

1. Employee's gross pay in average week was _____
2. Did the employee receive lodging or tips in addition to pay Yes No If yes, describe:

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

