



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: Southern Westchester BOCES 2. Employer FEIN: 136007351
- 3. Mailing Address: 17 Berkley Drive, Rye Brook, NY 10573
- 4. Location Address (if different): _____
- 5. Phone Number: (914) 937- 3820 6. Nature of Business or Industry Code: Education
- 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** 867139 Carrier/Group Name: Self Insured c/o Wright Risk Management
- 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: _____
- 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? _____

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): _____

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) _____

First MI Last

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? _____

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 an 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

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: _____

Reports should be filed by sending directly to the appropriate WCB district office (DO) at the address below with a copy sent to the insurance carrier:

- Albany DO - 100 Broadway-Menands, Albany NY 12241 866-750-5157** (for accidents in the following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington)
- Binghamton DO - State Office Building, 44 Hawley Street, Binghamton NY 13901 866-802-3604** (for accidents in the following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)
- Buffalo DO - Statler Towers, 107 Delaware Avenue, Buffalo NY 14202 866-211-0645** (for accidents in the following counties: Cattaraugus, Chautauqua, Erie, Niagara)
- Rochester DO - 130 Main Street West, Rochester NY 14614 866-211-0644** (for accidents in the following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates)
- Syracuse DO - 935 James Street, Syracuse NY 13203 866-802-3730** (for accidents in the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence)
- Downstate Centralized Mailing - PO Box 5205, Binghamton NY, 13902-5205 for all DO's in NYC 800-877-1373; in Hempstead 866-805-3630; in Hauppauge 866-681-5354; in Peekskill 866-746-0552** (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)