Employer's First Report of Work-Related Injury Worksheet

Per Section 110 of the Workers' Compensation Law a work-related injury or illness must be reported within 10 days of notice of the injury or be subject to a penalty. Please do not hesitate to contact us if you need assistance completing this form.

WCB Case # (if known) _____ Date of Injury _____
Carrier Case # (if known) _____ Insurance Carrier _____

Employer Information

Company Name _____
Unemployment Insurance # _____ Company FEIN _____
Company Mailing Address _____
City _____ State _____ Zip Code _____
Company Physical Address _____
City _____ State _____ Zip Code _____
Employer Contact Name _____ Phone Number _____
Policy # _____
Entity Name _____
Entity FEIN _____ Entity Effective Date _____

Employee Information

First Name _____ Middle Name/Initial _____
Last Name _____ Suffix _____
Date of Birth _____ SSN _____ Gender M _____ F _____
Mailing Address _____
City _____ State _____ Zip Code _____
Phone Number _____
Date of Hire _____ Job Title _____
Job Duties (or attached a current job description) _____
_____

Days Usually Worked ___M ___T___W___Th___F___S___S # of Days Worked per Week _____
Employment Status (full time, part time, seasonal) _____ Estimated Weekly Wage (gross) $ _____
Supervisor's Name _____

Injury Information

Time Employee started work on day of accident _____ AM____PM ____
Time of Injury _____ AM_____ PM _____
Did the Employee give notice of accident on the day of accident _____Yes _____No
If no, date notice given _____
If yes, to whom? _____
Was a Claimant Information Packet Provided? Yes_____ No _____ If yes, when _____
What was the Employee doing when Injured? _____
_____
How did the accident occur? (What caused the injury?)
_____
_____
Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc.) _____
_____
What body part(s) were injured? (i.e. left arm, right foot, head, etc.) _____
_____
Was an object involved? (i.e. hammer, ice, etc.) _____
To your knowledge, did the Employee have another work-related injury to the same body part or similar
Illness while working for you? Yes_____ No_____ If yes, please explain _____
_____
Death as a result of injury? Yes _____ No _____ Date of Death _____ Dependents
_____
Was the injury the result of the use or operation of a licensed motor vehicle? Yes_____ No_____
If accident involves employer's motor vehicle, please list automobile insurance information _____
_____

Medical Treatment

What was the date of the Employee's first treatment _____ None Received _____ Unknown
_____
Where did the Employee receive first medical treatment for this injury? On Site _____ ER _____
Doctor's Office _____ Clinic/Hospital/Urgent Care_____ Hospital Stay _____ Unknown__ _____
Who treated the Employee and where? _____
Is the Employee still being treated for this injury/illness? Yes _____ No _____ Unknown _____
If yes, name and address of treating doctor(s) _____
_____

Work Status

Last day worked _____ Date Employer knew of last day worked _____
First day out of work due to injury _____ Full wages paid for date of injury? Yes _____ No _____
Did Employee continue to pay salary? Yes _____ No _____ Last date paid _____
Are you requesting reimbursement ? Yes _____ No_____
Did Employee return to work? Yes _____ No _____ Return to work date _____
Did the Employee return to full or modified duty? Full_____ Modified _____
If modified, describe the physical restrictions _____
_____

Accident Location & Witnesses

Where did the accident/illness happen? (i.e. 1 Main St, Pottersville, NY 12345 at the front door)
_____
_____

Is the accident location the same as the company/entity physical address? Yes _____ No _____
Is this where the employee normally worked? Yes _____ No _____ If no, why was he/she at this location? _____
_____

Did supervisor see the injury happen? Yes _____ No _____

Witnesses Name	Witnesses Phone Number
_____	_____
_____	_____
_____	_____

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.

Signature of person preparing form _____ Date _____

Print Name _____

Title _____ Phone Number _____

Include any additional information that may be pertinent to the case below:
_____
_____
_____
_____
_____
_____
_____
_____
_____