WORKERS' COMPENSATION BOARD

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: L.I. LOCKSMITH & ALARM CO., INC. 2. Employer FEIN: 11-200988926

3. Mailing Address: 26 W. OLD COUNTRY RD.

4. Location Address (if different): HICKSVILLE , NY 11801

5. Phone Number: (516) 931-2273 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: NEW YORK STATE INSURANCE FUND

3. Policy Number: H 1361 807-9 Policy Period: From: 03 /01 /2012 To: 02 /28 /2013

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? _____

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)

EMPLOYEE'S NAME: _____ DATE OF INJURY/ILLNESS: ____/____/____
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? _____

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.) _____

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 Workers' Compensation Board at the address below with a copy sent to the insurance carrier:

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205