State of New York
WORKERS' COMPENSATION BOARD

EMPLOYEE'S STATEMENT OF INJURY AND CLAIM FOR COMPENSATION

C-3

Answer All Questions Fully - Type or Print Clearly

WCB Case Number (if known):

A. INJURED PERSON

1. Name ..... Date of Birth ...../...../.....
First Middle Last

2. Mailing Address .....
Number and Street (include Apartment No.) City State Zip Code

3. Social Security Number ..... Telephone Number ..... Gender: ❑ Male ❑ Female

4. Marital Status: ❑ Married ❑ Unmarried (Single or Divorced) ❑ Separated

B. EMPLOYER(S)

1. Employer ..... Telephone Number .....

2. Your Work Address .....
Number and Street City State Zip Code

3. Date of Hire ...../...../.....

4. Were you employed by any other employer(s) at the time of your injury/illness? ❑ Yes ❑ No

If yes, provide name(s): .....

If yes, did you lose time from work at the other employment(s) as a result of your injury/illness? ❑ Yes ❑ No

C. EMPLOYMENT

On the date of injury:

1. What was your job title or description? .....

2. What types of activities did you normally perform at work? (check all that apply) ❑ clerical ❑ computer operation ❑ education
❑ technical services ❑ physical labor ❑ operating heavy equipment ❑ factory work ❑ skilled trade ❑ service industry
❑ agriculture ❑ health field ❑ construction ❑ professional services ❑ civil service ❑ driving motor vehicles
❑ other (describe): .....

3. What was your status at the time of injury? ❑ Full Time ❑ Part Time ❑ Seasonal ❑ Volunteer ❑ Other

4. How much were you paid in a pay period? ..... How often were you paid? .....

5. Did you receive housing or other benefits in addition to salary? ❑ Yes ❑ No If yes, describe: .....
.....

D. OCCURRENCE OF INJURY/ILLNESS

1. Date and time of day of the injury/illness: .....

2. Work location where injury occurred: .....

3. Was this your normal work location? ❑Yes ❑ No If no, why were you at this location? .....
.....

4. What were you doing when the accident happened? .....
.....

5. How did the injury occur? (e.g., the employee tripped over a pipe and hit head on door jam) .....
.....
.....

D. OCCURRENCE OF INJURY/ILLNESS (*continued*)

6. Was an object (e.g., machinery, chemical, tool, etc.) involved in the accident? ❑ Yes ❑ No If yes, what was it? .....

7. Was the injury the result of the use or operation of a motor vehicle? ❑ Yes ❑ No

   If yes, ❑ your vehicle ❑ employer's vehicle ❑ other vehicle

   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: .....

   .....

8. Have you given your employer (or supervisor) notice of injury? ❑ Yes ❑ No

   If yes, notice was given ❑ orally ❑ in writing, to ..... Date notice provided ...../...../.....

9. Did anyone see your accident happen? ❑ Yes ❑ No If yes, list names and indicate if your supervisor was a witness:

   .....

10. Explain fully the nature of your injury/illness, including all body parts injured. (e.g., twisted ankle from tripping and cut to forehead)

    .....

    .....

E. MEDICAL TREATMENT

1. What was the date of your first treatment? ...../...../..... ❑ None received

2. Where did you receive your first medical treatment for your injury/illness? ❑ On site ❑ Doctor's office ❑ Emergency Room

   ❑ Clinic/ Hospital/Urgent Care ❑ Hospital Stay over 24 hours

   Name and address where you were treated: .....

   .....

3. Are you still being treated for this injury/illness? ❑ Yes ❑ No

4. Give the name and address of the doctor treating you for this injury/illness: .....

   .....

5. Have you ever had another injury to the same body part as your current injury? ❑ Yes ❑ No

   If yes, was the injury work related? ❑ Yes ❑ No If yes, were you working for the same employer? ❑ Yes ❑ No

   List the doctors who treated you for the previous injuries/illnesses: .....

   .....

F. RETURN TO WORK

1. Did you stop work because of your injury/illness? ❑ Yes ❑ No If yes, on what date? ...../...../.....

2. Have you returned to work? ❑ Yes ❑ No If yes, ❑ regular duty ❑ light duty On what date? ...../...../.....

3. If yes, who are you currently working for? ❑ Same employer ❑ New employer ❑ Self employed

4. How much are you paid in a pay period? ..... How often are you paid? .....

Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self insurer, any information containing any false material statement or conceals any material fact shall be guilty of a crime and subject to substantial fines and imprisonment.

I am giving notice of a claim for workers' compensation benefits to the Chair, Workers' Compensation Board, for disability resulting from an accidental injury or occupational disease. The above information is true to the best of my knowledge and belief.

An individual may sign on behalf of the claimant only if he or she is legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated.

Signed by claimant.....Date...../...../.....

On behalf of claimant.....Relation to claimant.....Date...../...../.....