Employee Claim

State of New York - Workers' Compensation Board

C-3

Fill out this form to ask for workers' compensation benefits because of a work injury or work-related illness. Type of print neatly.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Injured Person)

1. Name _____ Date of Birth _____

2. Mailing Address _____

3. Social Security Number _____ Phone Number _____ Gender: ☐ Male ☐ Female

B. YOUR EMPLOYER(S)

1. Employer _____ Phone Number _____

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

3. Date you were hired _____

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. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? (check all that apply)

☐ agriculture	☐ education	☐ physical labor	☐ skilled trade
☐ clerical	☐ factory work	☐ professional services	☐ technical services
☐ computer operation	☐ health field	☐ sales	
☐ construction	☐ operating heavy equipment	☐ service industry	
☐ driving motor vehicles	☐ other (*describe*): _____		

3. Was your job? (check one) ☐ 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 lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date and time of day of the injury or date of onset of illness? _____

2. Where did the injury/illness happen (e.g., 1 Main Street, at the front door) _____

3. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

4. What were you doing when you were injured or became ill? _____

D. YOUR INJURY OR ILLNESS *continued*

5. How did the injury/illness occur? (e.g., I tripped over a pipe and fell on the floor) _____

_____

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

_____

_____

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

8. 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 License plate number _____

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

_____

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

If yes, notice was given, ☐ orally ☐ in writing, to _____ Date notice provided _____

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

_____

E. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

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

Give the name and address of the doctor(s) treating you for this injury/illness: _____

_____

4. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No

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

List the doctor(s) 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 ☐ restricted duty On what date? _____

If yes, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed

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

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.

I am hereby making a claim for benefits under the Workers' Compensation Law. The above information is true to the best of my knowlegde and belief.

Claimant's Signature _____ Print Name _____ Date _____

On behalf of Claimant _____ Print Name _____ Date _____