State of New York - Workers' Compensation Board

EMPLOYEE'S CLAIM FOR COMPENSATION

IMPORTANT: Your Social Security Number Must Be Entered:
IMPORTANTE: El Numero de su Seguro Social Debe Ser Indicado: ☐☐☐ ☐☐ ☐☐☐☐

ANSWER ALL QUESTIONS FULLY - PRINT OR TYPE CLEARLY

WCB Case No. (If Known)..... Carrier Case No. (If Known).....

A. Injured Person

1. Name..... (First Name / Middle Name / Last Name)
2. Mailing Address..... (Number and Street (include Apartment No.) / City / State / Zip Code)
3. Sex: ☐ Male ☐ Female Date of Birth.....Telephone No. ( ).....
4. Do you speak English? ☐ Yes ☐ No If not, what language do you speak?.....
5. Name of union and local number, if member.....
6. State what your regular work/occupation was.....
7. Wages or average earnings per day, including overtime, board, rent and other allowances.....
8. Were you paid full wages for the day of injury? ☐ Yes ☐ No
9. Your work week at time of injury was: ☐ Five day ☐ Six day ☐ Seven day ☐ Other.....

B. Employer(s)

1. Employer.....Telephone No. ( ).....
2. Employer's Address.....
3. Were you employed by any other employer or employers at the time of your injury/illness? ☐ Yes ☐ No
4. If Yes, did you lose time from work at this other employment as a result of your injury/illness? ☐ Yes ☐ No

C. Place & Time

1. Address where injury occurred.....County.....
2. Date of Injury.....,19.....at .....o'clock, ☐ AM ☐ PM

D. The Injury

1. How did injury occur?.....
.....
.....

E. Nature and Extent of Injury

1. State fully the nature of your injury/illness, including all parts of body injured:.....
.....
2. Date you stopped work because of this injury? .....,19.....
3. Have you returned to work? ☐ Yes ☐ No If yes, on what date?.....,19.....
4. Does injury keep you from work? ☐ Yes ☐ No
5. Have you done any work during period of disability? ☐ Yes ☐ No
6. Have you received any wages since your injury? ☐ Yes ☐ No

F. Medical Benefits

1. Did you receive or are you now receiving medical care? ☐ Yes ☐ No
2. Are you now in need of medical care? ☐ Yes ☐ No
3. Name of attending doctor:.....
Doctor's address.....
4. If you were in a hospital, give the dates hospitalized:.....
Name of hospital.....
Hospital's address.....

G. Comp. Payments

1. Have you received or are you now receiving workers' compensation payments for the injury reported above? ☐ Yes ☐ No
2. Do you claim further workers' compensation payments? ☐ Yes ☐ No

H. Notice

1. Have you given your employer (or supervisor) notice of injury? ☐ Yes ☐ No
2. If yes, notice was given ☐ orally ☐ in writing, on ....., 19.....
to.....

I hereby present my claim to the Chair, Workers' Compensation Board, for compensation for disability resulting from an accidental injury or occupational disease arising out of and in the course of my employment and not occasioned by my willful intention or solely through intoxication, and in support of it I make the foregoing statement of facts.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Signed by.....Dated.....
(Claimant)

(SEE OTHER SIDE FOR IMPORTANT INFORMATION - VEASE AL DORSO PARA INFORMACION DE IMPORTANCIA)

C-3 (6-94)