



# EMPLOYER'S REPORT OF WORK-RELATED INJURY/ILLNESS

State of New York - Workers' Compensation Board

# C-2

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

- Employer: \_\_\_\_\_ 2. Employer FEIN: \_\_\_\_\_
- Mailing Address: \_\_\_\_\_
- Location Address (if different): \_\_\_\_\_
- Phone Number: (\_\_\_\_) \_\_\_\_\_ 6. Nature of Business or Industry Code: \_\_\_\_\_
- 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.*

- Board W Number: **W** \_\_\_\_\_ 2. Carrier/Group Name: \_\_\_\_\_
- Policy Number: \_\_\_\_\_ Policy Period: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_
- If Carrier Unknown, Insurance Agent Name: \_\_\_\_\_ 5. Phone Number: (\_\_\_\_) \_\_\_\_\_

## C. EMPLOYEE'S PERSONAL INFORMATION

- Name: \_\_\_\_\_ 2. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First MI Last
- Mailing Address: \_\_\_\_\_
- Social Security Number: \_\_\_\_\_ 5. Contact Phone Number: (\_\_\_\_) \_\_\_\_\_ 6. Gender:  Male  Female

## D. EMPLOYEE'S INJURY OR ILLNESS

- Time of day employee began work on date of injury: \_\_\_\_\_  AM  PM 2. Time of injury: \_\_\_\_\_  AM  PM
- 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.*
- Have you given the employee a Claimant Information Packet?  Yes  No If yes, give date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Where did the injury/illness happen (e.g., 1 Main St., Pottersville, at the front door): \_\_\_\_\_
- Was this location where the employee normally worked?  Yes  No If no, why was the employee there? \_\_\_\_\_
- Employee's supervisor: \_\_\_\_\_ 8. Did supervisor see injury happen?  Yes  No  Unknown
- Did anyone else see the injury happen?  Yes  No  Unknown If yes, give name(s): \_\_\_\_\_
- 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 appropriate WCB district office (DO) at the address below with a copy sent to the insurance carrier:

- Albany DO - 100 Broadway-Menands, Albany NY 12241 866-750-5157 (for accidents in the following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington)
- Binghamton DO - State Office Building, 44 Hawley Street, Binghamton NY 13901 866-802-3604 (for accidents in the following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)
- Buffalo DO - Statler Towers, 107 Delaware Avenue, Buffalo NY 14202 866-211-0645 (for accidents in the following counties: Cattaraugus, Chautauqua, Erie, Niagara)
- Rochester DO - 130 Main Street West, Rochester NY 14614 866-211-0644 (for accidents in the following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates)
- Syracuse DO - 935 James Street, Syracuse NY 13203 866-802-3730 (for accidents in the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence)
- Downstate Centralized Mailing - PO Box 5205, Binghamton NY, 13902-5205 for all DO's in NYC 800-877-1373; in Hempstead 866-805-3630; in Hauppauge 866-681-5354; in Peekskill 866-746-0552 (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)

516-8770094  
603-513-7007