

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

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/liness 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.

	WICB Case Number (f you know it):	Date of Injury/filmess:	/	/	
	Carrier Case Number (f you know it):	Date of this Report:			
4. 6	EMPLOYER INFORMATION				
	1. Employer	2. Employer	FEIN		
- }	3. Mailing Address:				
- 8	Location Address (f different):				
	5. Phone Number: (	ness or Industry Code:			
	7. OSHA Case Number (f known): #. No INSURANCE CARRIER / SELF-INSURED EMPLOYER	Ul Employer Reg Number:		- 2	
	If individually self-insured, enter your Board W Number and skip to 3e 1.Board W Number: W				
	3. Policy Number Policy Period				
- 3	4. If Carrier Unknown, Insurance Agent Name:	5. Phone I	lumber: (		
2 6	EMPLOYEE'S PERSONAL INFORMATION				
	1. Name:	2. Date	of Birth:	1	
	3. Mailing Address:				
	4. Social Security Number: 5. Contact Phone Numi		6. Gender: 🗆	Male Female	
	EMPLOYEE'S INJURY OR ILLNESS				
-	1. Time of day employee began work on date of injury.	LM PM 2. Time of injury:_		AM _ PA	
- 8	3. Has the employee given you notice of injury/filness? Yes No.				
	# yes, notice was given to:	braity 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.				
- 3	. Have you given the employee a Claimant Information Packet? Yes No If yes, give date://				
	<ol><li>Where did the injury/liness happen (e.g., 1 Main St., Pottersville, at the fr</li></ol>	ront door):			
	S. Was this location where the employee normally worked?   Yes  No If no, why was the employee there?				
4	7. Employee's supervisor	Did supervisor see injury happen	⊘ □Yes [	_No □Unknow	
3	9. Did anyone else see the injury happen?   Yes   No Unknown	If yes, give name(s):			

# Form C 2 Workers Compensation Board

**Mike Jess** 

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