

EMPLOYER'S REPORT OF WORK-RELATED INJURY/ILLNESS

C-2

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/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

1. Employer: _____ 2. Employer FEIN: _____

3. Mailing Address: _____

4. Location Address (if different): _____

5. Phone Number: (____) _____ 6. Nature of Business or Industry Code: _____

7. 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.

1. Board W Number: W _____ 2. Carrier/Group Name: _____

3. Policy Number: _____ Policy Period: From: ____/____/____ To: ____/____/____

4. If Carrier Unknown, Insurance Agent Name: _____ 5. Phone Number: (____) _____

C. EMPLOYEE'S PERSONAL INFORMATION

1. Name: _____ 2. Date of Birth: ____/____/____

3. Mailing Address: _____

4. Social Security Number: _____ 5. Contact Phone Number: (____) _____ 6. Gender: ☐ Male ☐ Female

D. EMPLOYEE'S INJURY OR ILLNESS

1. Time of day employee began work on date of injury: _____ ☐ AM ☐ PM 2. Time of injury: _____ ☐ AM ☐ PM

3. 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.

4. Have you given the employee a Claimant Information Packet? ☐ Yes ☐ No If yes, give date: ____/____/____

5. Where did the injury/illness happen (e.g., 1 Main St., Pottersville, at the front door): _____

6. Was this location where the employee normally worked? ☐ Yes ☐ No If no, why was the employee there? _____

7. Employee's supervisor: _____ 8. Did supervisor see injury happen? ☐ Yes ☐ No ☐ Unknown

9. Did anyone else see the injury happen? ☐ Yes ☐ No ☐ Unknown If yes, give name(s): _____

10. What was the employee doing when he/she was injured or became ill? (e.g., unloading a truck, stocking a shelf, typing annual report): _____

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Jicheng Xie



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Table of Contents Form C 2 Workers Compensation Board

1. Understanding the eBook Form C 2 Workers Compensation Board
 - The Rise of Digital Reading Form C 2 Workers Compensation Board
 - Advantages of eBooks Over Traditional Books
2. Identifying Form C 2 Workers Compensation Board
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Form C 2 Workers Compensation Board
 - User-Friendly Interface
4. Exploring eBook Recommendations from Form C 2 Workers Compensation Board
 - Personalized Recommendations
 - Form C 2 Workers Compensation Board User Reviews and Ratings
 - Form C 2 Workers Compensation Board and Bestseller Lists
5. Accessing Form C 2 Workers Compensation Board Free and Paid eBooks
 - Form C 2 Workers Compensation Board Public Domain eBooks
 - Form C 2 Workers Compensation Board eBook Subscription Services
 - Form C 2 Workers Compensation Board Budget-Friendly Options

6. Navigating Form C 2 Workers Compensation Board eBook Formats
 - ePub, PDF, MOBI, and More
 - Form C 2 Workers Compensation Board Compatibility with Devices
 - Form C 2 Workers Compensation Board Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Form C 2 Workers Compensation Board
 - Highlighting and Note-Taking Form C 2 Workers Compensation Board
 - Interactive Elements Form C 2 Workers Compensation Board
8. Staying Engaged with Form C 2 Workers Compensation Board
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Form C 2 Workers Compensation Board
9. Balancing eBooks and Physical Books Form C 2 Workers Compensation Board
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Form C 2 Workers Compensation Board
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine Form C 2 Workers Compensation Board
 - Setting Reading Goals Form C 2 Workers Compensation Board
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Form C 2 Workers Compensation Board
 - Fact-Checking eBook Content of Form C 2 Workers Compensation Board
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
 - Integration of Multimedia Elements

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- Interactive and Gamified eBooks

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