

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

EMPLOYER'S REPORT OF WORK-RELATED ACCIDENT/OCCUPATIONAL DISEASE

Send this notice directly to the Chair, Workers' Compensation Board at the address shown on the reverse side within ten (10) days after an accident occurs. ANSWER ALL QUESTIONS FULLY. A copy should also be provided to or retained by your workers' compensation insurance carrier.

Any employer who fails to timely file Form C-2, as required by Section 110 of the Workers' Compensation Law, is subject to a fine of not more than \$1,000. In addition, the Board or Chair may impose a penalty of up to \$2,500.

TYPEWRITER PREPARATION IS STRONGLY RECOMMENDED - INCLUDE ZIP CODE IN ALL ADDRESSES-EMPLOYEE'S S.S.NO. MUST BE ENTERED BELOW ↓

WCB CASE NO. (if known)	CARRIER CASE NO.	CARRIER CODE NO.	WC POLICY NO.	DATE OF ACCIDENT	EMPLOYEE'S S.S. NO.	
		W		m m d d y y		
1.(a) EMPLOYER'S NAME		(b) EMPLOYER'S MAILING ADDRESS		(c) OSHA CASE/FILE NO.		
(d) LOCATION (if Different From Mailing Address)		(e) NATURE OF BUSINESS (Principal Products, Services, etc.)		(f) NY UI EMPLOYER REG. NO.	(g) FEIN - if UI Emp. Reg. No. Unknown	
2.(a) INSURANCE CARRIER			(b) CARRIER'S ADDRESS			
3.(a) INJURED EMPLOYEE (First, M.I., Last)			(b) ADDRESS (Includes No. & Street, City, State, Zip & Apt. No.)			
A C C I D E N T	4. (a) ADDRESS WHERE ACCIDENT OCCURRED			(b) COUNTY	(c) WAS ACCIDENT ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	5. HOUR EMP. BEGAN WORK h h m m <input type="checkbox"/> AM <input type="checkbox"/> PM	6. TIME OF ACCIDENT h h m m <input type="checkbox"/> AM <input type="checkbox"/> PM	7. DEPT. WHERE REGULARLY EMPLOYED	8.(a) DATE STOPPED WORK BECAUSE OF THIS INJURY/ILLNESS m m d d y y	(b) WAS EMPLOYEE PAID IN FULL FOR DAY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I N J U R E D	9. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	10. DATE OF BIRTH m m d d y y	11. OCCUPATION (Specific job title at which employed)		12. DATE HIRED m m d d y y	
	13.(a) AVERAGE EARNINGS PER WEEK? \$ 0 0	(b) TOTAL EARNINGS PAID DURING 52 WEEKS PRIOR TO DATE OF ACCIDENT (Include bonuses, overtime, value of lodging, etc.) \$ 0 0		14. (a) EMPLOYEE IS: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	(b) INJURED EMPLOYEE'S WORK WEEK (Check days usually worked.) Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun <input type="checkbox"/>	
N A T U R E O F I N J U R Y	15. NATURE OF INJURY AND PART(S) OF BODY AFFECTED			16. (a) DID YOU PROVIDE MEDICAL CARE? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	17. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> Yes <input type="checkbox"/> No			18. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	19. (a) NAME AND ADDRESS OF DOCTOR			(b) NAME AND ADDRESS OF HOSPITAL		
20. (a) HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No			(b) IF YES, GIVE DATE: m m d d y y	(c) AT WHAT WEEKLY WAGE? \$ 0 0		
NOTE: FORM C-11 MUST BE FILED EACH TIME THERE IS A CHANGE IN EMPLOYMENT STATUS						
C A U S E O F A C C I D E N T	21. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.)					
	22. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)					
	23. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE. e.g., the machine employee struck against or which struck him/her, the vapor or poison inhaled or swallowed, the chemical that irritated his/her skin. In cases of strains, the thing (s)he was lifting, pulling, etc.					
FATAL CASES	24. (a) DATE OF DEATH m m d d y y		(b) NAME AND ADDRESS OF NEAREST RELATIVE		(c) RELATIONSHIP	
P R E P A R A T I O N	DATE EMPLOYER/SUPERVISOR FIRST KNEW OF INJURY m m d d y y		DATE OF THIS REPORT m m d d y y		IF FORM IS SUBMITTED BY EMPLOYER, COMPLETE A & B BELOW. IF FORM IS SUBMITTED BY THIRD PARTY, COMPLETE A,B,C & D BELOW.	
	A. EMPLOYEE PREPARING FORM OR SUPPLYING INFORMATION TO THIRD PARTY			B. TITLE TELEPHONE NUMBER & EXTENSION		
	C. IF REPORT PREPARED BY THIRD PARTY, COMPANY NAME AND ADDRESS					
	D. THIRD PARTY CONTACT NAME			TELEPHONE NUMBER & EXTENSION		

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