STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
100 BROADWAY-MENANDS
ALBANY, NY 12241
(877) 632-4996

You were injured at work. What now?

The New York State Workers' Compensation Board has received notice you suffered a workplace injury or illness, so we're preparing a workers' compensation case in your name. You may have already received medical treatment. If you haven't, you should seek medical care as soon as possible.

A Worker's Responsibilities

- You must tell your employer, in writing, when, where and how you were injured. Do this within 30 days of injury.
- *Medical reports are necessary for your case.* Advise your doctors that you have a work-related injury, and give the name of your employer. Do not pay for your care yourself or use other health insurance. Tell your doctor to file reports with the Board and with your employer or its insurance carrier. If your case is disputed, the Board needs a medical report on your injury to begin resolving your claim.

Starting a Case

Once your employer knows of your injury, it must notify this Board by filing a C-2 form. *You should file an employee claim (C-3 form) reporting your injury as soon as possible.* (You **must** notify the Board of your injury or illness within two years.) If you injured the same body part before, or had a similar illness, you must also file a Form C-3.3.

If you haven't already filed a C-3 or C-3.3 (if necessary), there are three ways to do it.

- Visit *www.wcb.state.ny.us/content/main/onthejob/howto.jsp* to complete the form.
- Complete the enclosed paper forms, and mail them to the Board.
- Call 1-866-396-8314. A Board employee will complete the form with you.

Health Care Bills

Do not pay your doctor or hospital. Those bills are paid by the insurer unless the Board disallows your case. If your case is disputed, the providers are paid when the Board decides your case. If the Board decides against you, or if *you don't pursue a case, you will have to pay the doctor or hospital.*

Your employer's insurance covers medically necessary drugs and equipment your doctor prescribes. You're also entitled to carfare or necessary expenses incurred when traveling for treatment. (Get receipts for those expenses.)

Generally, you can choose any doctor authorized by the Board. You can also use occupational health clinics. However, if your employer's insurer has a preferred provider organization to provide care for workers' compensation injuries, you must get your initial treatment from those providers. If that insurer also has a pharmacy or diagnostic network, you must get service within these networks. If the carrier uses these networks, it must also tell you its service providers and how to use them.

Benefits for Lost Wages

You are entitled to a portion of your lost wages if your injury affects you in one or more ways:

1. It keeps you from work for more than seven days;
2. Part of your body is permanently disabled;
3. Your pay is reduced because you now work fewer hours or do other work.

An employer or insurer can accept your claim and begin paying your lost wage benefit promptly. Sometimes, employers and carriers dispute a claim. When that occurs, the Board strives to resolve most cases within 90 days.

You may hire an attorney or licensed representative, who can be helpful with complex or disputed claims, but it isn't required. The Board sets their fees and they will be deducted from your lost wages award. You or your family should not pay anything directly to your attorney or licensed representative.

If your case is disputed, you may receive disability benefits while the case is heard. You'd pay them back out of your lost wages award. To get a DB-450 form, visit *www.wcb.state.ny.us/content/main/forms/db450.pdf* or a Board office, or call (800) 353-3092.

Help is Available

People sometimes need help getting back to work. Your employer may have a *return to work* program that can get you back to work in light duty or an alternative position while you heal. An injury can also cause family or financial problems. The Workers' Compensation Board has rehabilitation counselors and social workers to help. Call (877) 632-4996 for more assistance.

What's Next?

Your employer or its insurance carrier will contact you if your claim is accepted. When that happens, your treatment will be paid and lost wage benefits begin. If your case is challenged, the Board will notify you about resolving the case. If more information is necessary, the Board will contact you and tell you how to file it.

Important Contact Information

Workers' Compensation Board	(877)632-4996	General_Information@wcb.state.ny.us
Disability Benefits	(800)353-3092	www.WCB.State.NY.US
NYS Bar Association Lawyer Referral and Information Service	(800)342-3661	lr@nysba.org.

Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: _____/_____/_____

3. Mailing address: _____ (Number and Street/PO Box / City / State / Zip Code)

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

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: _____/_____/_____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: _____/_____/_____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____ DATE OF INJURY/ILLNESS: _____/_____/_____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: _____/_____/_____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? _____/_____/_____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? _____/_____/_____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? _____/_____/_____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
Name and address where you were first treated: _____
_____ Phone Number: (_____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
Give the name and address of the doctor(s) treating you for this injury/illness: _____
_____ Phone Number: (_____)_____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
_____
_____
_____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: _____/_____/_____

On behalf of Employee: _____ Print Name: _____ Date: _____/_____/_____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: _____/_____/_____

Print Name: _____ Title: _____

ID No., if any: **R** _____ If Licensed Representative, License No.: _____ Expiration Date: _____/_____/_____

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

WCB Case No. *(if you know it):*_____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:_____ 2. Social Security Number:_____-_____-_____
3. Mailing Address: _____
4. Date of Birth: _____/_____/_____ 5. Date of the current injury/illness: _____/_____/_____
6. Current injury/illness, including all body parts injured:_____

_____

7. Your legal representative's name and address (if any):_____

_____

☐ *Check here if you allow your health care provider(s) to release **mental health care** information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:_____ 2. Phone Number: (_____)_____
3. Mailing Address: _____
4. Other provider (if any):_____ 5. Phone Number: (_____)_____
6. Mailing Address:_____

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____

Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

_____

Your name Relationship to Claimant Signature (ink only -- use blue ballpoint pen, if possible.) Date

Versión en español al reverso de la forma.

Divulgación limitada de información sobre la salud
(HIPAA)

C-3.3

Estado de NuevaYork - Junta de Compensación Obrera (WCB)

WCB Case No. (if you know it) (Número de caso WCB *[si lo sabe])*

Al reclamante: Si usted recibió tratamiento por una lesión anterior en la misma parte del cuerpo o por una enfermedad similar a la que motiva ahora su reclamación, complete este formulario. Este formulario les permite a los proveedores de salud que usted señala a continuación divulgar a la compañía de seguros de compensación obrera de su empleador la información sobre su salud relacionada con su lesión/enfermedad anterior. La Ley federal HIPAA (Ley de portabilidad y responsabilidad del seguro de salud de 1996) establece que usted tiene derecho a recibir una copia de este formulario. Si no comprende este formulario, hable con su representante legal. Si no tiene un representante legal, el Representante de los obreros lesionados de la Junta de Compensación Obrera puede ayudarlo. Llame al 800-580-6665.

Al proveedor de salud: Una **copia** de esta divulgación, redactada según lo que establece la ley HIPAA, le permite divulgar información sobre la salud. Si envía los registros al asegurador de compensación obrera del empleador en respuesta a la presente divulgación, también debe enviar por correo copias al representante legal del reclamante. (Si a continuación no se especifica un representante legal, envíe las copias al reclamante). Los proveedores de salud que divulgan los registros deben cumplir con las leyes del estado de Nueva York y la HIPAA.

Esta divulgación es:

- **Voluntaria.** Su(s) proveedor(es) de salud deben otorgarle la misma atención, condiciones de pago y beneficios, independientemente de que usted firme este formulario o no.
- **Limitada.** Le otorga a su(s) proveedor(es) de salud permiso para divulgar únicamente los registros médicos que se relacionen con la enfermedad/afección anterior que usted describe a continuación.
- **Temporal.** Termina cuando se otorgue o desestime su actual reclamación de compensación y se hayan agotado todas las apelaciones.
- **Revocable.** Usted puede cancelar esta divulgación en cualquier momento. Para hacerlo, envíe una carta al (a los) proveedor(es) de salud que se indican en este formulario. Además, envíe una copia de su carta a la compañía de seguros de compensación obrera de su empleador y a la Junta de Compensación Obrera. *Nota: No podrá cancelar esta divulgación en lo que se refiere a registros médicos que ya se hayan provisto.*
- **Solamente para registros.** Le otorga a su(s) proveedor(es) de salud que se indica(n) en este formulario permiso para enviar copias de sus registros de salud a la compañía de seguros de compensación obrera de su empleador.

Este formulario NO autoriza a su(s) proveedor(es) de salud a divulgar los siguientes tipos de información:

- **Información relacionada con el VIH**
- **Notas de terapia psicológica**
- **Tratamientos por abuso de alcohol o drogas**
- **Tratamiento de salud mental** (a menos que usted lo indique a continuación)
- **Información verbal** (sus doctores no pueden hablar con nadie sobre su información de salud)

Los registros médicos divulgados se incorporarán a su expediente de compensación obrera y son confidenciales conforme a la Ley de compensación obrera.

CONTESTA LAS SIGUIENTES PREGUNTAS, EN INGLÉS SI ES POSIBLE, EN LOS ESPACIOS PROVISTOS Y FIRMA AL FRENTE DE LA FORMA.

A. YOUR INFORMATION (Claimant) INFORMACIÓN PERSONAL (Reclamante)

1. Name (Nombre)
2. Social Security Number (Número de seguro social)
3. Mailing Address (Dirección postal)
4. Date of Birth (Fecha de nacimiento)
5. Date of the current injury/illness (Fecha de la lesión/enfermedad actual)
6. Current injury/illness, including all body parts injured (Descripción de la lesión/enfermedad actual, incluyendo todas las partes del cuerpo lesionadas)
7. Your legal representative's name and address (if any) (Nombre y dirección de su representante legal [si corresponde])

Check here if you allow your health provider(s) to release ***mental health care*** *information. (Marque aquí si autoriza a su(s) proveedor(es) de salud a divulgar información sobre* ***tratamientos de salud mental****.)*

B. YOUR HEALTH CARE PROVIDERS (List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers, attach their contact information to this form.

SU(S) PROVEEDOR(ES) DE SALUD (Enumere todos los proveedores de salud que le han tratado por lesiones previas a las mismas areas del cuerpo ó por enfermedades semejantes.Si son más de 2 proveedores, adjunte su información de contacto a este formulario.)

1. Provider (Proveedor de salud)
2. Phone Number (N° de teléfono)
3. Mailing Address (Dirección postal)
4. Other provider (if any) (Otro proveedor [si corresponde])
5. Phone Number (N° de teléfono)
6. Mailing Adress (Dirección postal)

C. READ AND SIGN BELOW

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above. **LEA Y FIRME A CONTINUACIÓN.** Por la presente solicito que los proveedores de salud aquí enumerados le provean al asegurador de compensación obrera de mi patrono copias de todos los records médicos relacionados a cualquier lesión/enfermedad aquí enumeradas.

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below: (**Si el reclamante no puede firmar**, la persona que firme el formulario en su nombre y representación debe llenar y firmar a continuación)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Claimant's signature (Firma del reclamante) use solo tinta - preferiblemente azul | Date (Fecha)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Your name (Su nombre) | Relationship to Claimant (Relación con el reclamante) | Signature(Firma) | Date(Fecha)

Instructions for Completing Form C-3, "Employee Claim"

Please complete this form and send it to your local Workers' Compensation Board district office (DO) to apply for workers' compensation benefits. The addresses are listed at the bottom of these instructions. If you need additional help in completing this form, contact the Workers' Compensation Board at **1-877-632-4996. You may also fill this form out online at: http://www.wcb.state.ny.us/**

If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/illness on the top of page two.

Section A - Your Information (Employee):

Item 1: Enter your full name, including first name, middle initial, and last name.
Item 2: Enter your date of birth in month/day/year format. Include the four digit year.
Item 3: Enter your mailing address, including P.O. Box, if applicable, city or town, state, and Zip code.
Item 4: Enter your Social Security Number. This is very important to help service your claim faster.
Item 5: Indicate the primary contact phone number, including area code. This may include a cell phone number.
Item 6: Indicate your gender (Male or Female).
Item 7: Board hearings are conducted in English. If you will need a translator to understand the proceeding, the Board will provide one. Check Yes and indicate the language needed.

Section B - Your Employer(s):

Item 1: Indicate the employer you were working for at the time you were injured or became ill.
Item 2: Enter the phone number for this employer, either a primary contact number or the number for your supervisor.
Item 3: Enter the employer's address, including P.O. Box, if applicable, city or town, state, and Zip code.
Item 4: Indicate the date you were hired by this employer.
Item 5: Enter your direct supervisor's name, whom you report to on a regular basis.
Item 6: If you have more than one job, please indicate the names and addresses of all other employers you work for besides the one you were injured at. Please attach a separate sheet if you need more room.
Item 7: Check Yes if you lost time from any of your other jobs as a result of your injury or illness; otherwise, check No.

Section C - Your Job on the Date of the Injury or Illness:

Item 1: Indicate your current job title or job description (e.g., warehouse worker).
Item 2: Indicate your typical work activities for this job (e.g., keeping inventory, unloading trucks, etc.).
Item 3: Check the type of job you had.
Item 4: Enter your gross pay (before taxes) per pay period.
Item 5: Indicate how often you received a paycheck (weekly, bi-weekly, etc.).
Item 6: Indicate if you received any tips or lodging in addition to your regular pay. If you did, describe them.

Section D - Your Injury or Illness:

Item 1: Enter the date when you were injured or the first date you noticed you became ill. Enter the date in month/day/year format. Include the four digit year. If this is an illness or occupational disease, then skip item 2.
Item 2: Enter the time when the injury occurred. Check whether it was AM or PM.
Item 3: Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
Item 4: Check whether this was your normal work location. If it was not, explain why you were at this location.
Item 5: Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.
Item 6: Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
Item 7: Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible. (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now.)
Item 8: Indicate if some object was involved in the accident OTHER THAN a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
Item 9: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.
Item 10: Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.
Item 11: Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

Section E - Return to Work:

Item 1: If you stopped working as a result of your work-related injury/illness, check Yes and indicate on what date you stopped working. If you have not stopped working, check No and skip to the next section.

Section E - Return to Work (cont):

Item 2: If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)

Item 3: If you have returned to work, indicate who you are working for now.

Item 4: Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

Section F - Medical Treatment for This Injury or Illness:

Item 1: If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.

Item 2: Check if you were first treated on the job for this injury or illness.

Item 3: Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).

Item 4: If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise check No.

Item 5: If you believe you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**

Item 6: If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for "Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative **must** complete and sign the attorney/representative's certification section on the bottom of page 2.

What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the nearest Workers' Compensation Board Office. (See below.) Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, telephone or visit the nearest Workers' Compensation Board Office listed below.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed,
   the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, his/her fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

This form should be filed by sending directly to the appropriate WCB district office (DO) at the address listed below:

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 NY13901 (866) 802-3604 (for accidents in the following counties: Broome, Chemung, Chenango, Cortland,Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)

Buffalo DO - 295 Main Street, Suite 400, Buffalo NY 14203 (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)

THE CITY OF NEW YORK
WORKERS' COMPENSATION CLAIM INITIATION
EMPLOYEE STATEMENT

FISA FORM WCS-110 (1/01)

CLAIM NUMBER

INJURED EMPLOYEE NAME

FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

EMPLOYEE'S ADDRESS

STREET LOCATION | APT #, FL.#, BOX #

BORO, CITY OR TOWN | STATE | ZIP

DATE OF ACCIDENT / INJURY MM DD YYYY

TIME OF ACCIDENT HH : MM AM ☑ PM ☐

WORK TEL # (AREA CD) | EXTENSION

HOME TEL # (AREA CD)

DATE OF STATEMENT MM DD YYYY

OF WITNESS(ES)

SUPERIOR NOTIFIED

FIRST NAME | M.I. | LAST NAME | DATE FIRST NOTIFIED MM DD YYYY

TITLE

WORK TEL # (AREA CD) | EXTENSION

DESCRIBE LOCATION WHERE ACCIDENT OCCURRED

☐ CONTINUATION #1 ATTACHED

DESCRIBE FULLY HOW ACCIDENT OCCURRED

☐ CONTINUATION #2 ATTACHED

DESCRIBE OBJECT OR SUBSTANCE THAT CAUSED INJURY

☐ CONTINUATION #3 ATTACHED

DESCRIBE NATURE AND EXTENT OF INJURY (INCLUDING AFFECTED BODY PARTS)

☐ CONTINUATION #4 ATTACHED

NAME (PLEASE PRINT) | TITLE | TEL.#

SIGNATURE | DATE

THE CITY OF NEW YORK

Election of Rate of Charge Against Annual and/or Sick Leave Balances
For Absence Due To Injury Sustained in the Performance of Official Duties

(Pursuant to Regulation 7.0 of the Leave Regulations for employees who are under the Career and Salary Plan)

INSTRUCTIONS: The injured employee, or an authorized person acting in his behalf, should submit this election notice (in duplicate) to the head of his department or agency within the first seven calendar days of absence due to injury sustained in the performance of official duties.

I, _____, employed in _____,
(Print name of injured employee) **(Print name of city department or agency)**
in a position which is subject to the Leave Regulations for employees who are under the Career and Salary Plan, or my authorized agent, do hereby elect the option designated below, subject to the conditions attached thereto as the one to be applied in determining the charge, if any to be made against my annual and/or sick leave balances for absence due to injury sustained in the performance of my official duties:

(Check one option only)

☐ **OPTION** 1: I elect to receive the difference between the amount of my weekly salary and the compensation rate, subject to the following conditions:

(a) A pro-rated charge shall be made against my sick leave and/or annual leave balances equal to the number or working days absence less the number or working days represented by the Workers' Compensation payments, and:
(b) My accrued sick leave and/or annual leave balances, or such leave credits advanced to me in accordance with the Career and Salary Plan Leave Regulations are adequate to meet the charges made against them for supplementary pay, and:
(c) The injury sustained by me was not the result of my willful gross disobedience of salary rules or my willful failure to use a safety device, nor was I under the influence of alcohol or narcotics at time of injury, nor did I willfully intend to bring about injury or death upon myself or another, and:
(d) Such medical examinations will be undergone by me as are requested by the Workers' Compensation Division of the Law Department and my agency, and when found fit for duty by said physicians, I shall return to my employment.

☐ **OPTION 2**: I elect to receive Workers' Compensation benefits in their entirety as of _____ with no charge or additional charge against sick and/or annual leave.

<table>
<tr><td>Injured employee's signature ⇨</td><td></td><td>Date</td></tr>
<tr><td rowspan="7">This section should be completed only if the injured employee cannot sign and must designate an authorized person to sign in his behalf.</td><td colspan="2">Authorized designee's name (print)</td></tr>
<tr><td colspan="2">Authorized designee's address</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>Authorized designee's signature</td><td>Date</td></tr>
<tr><td colspan="2">Witness' name (print)</td></tr>
<tr><td colspan="2">Witness' address</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td></td><td>Witness' signature</td><td>Date</td></tr>
</table>

Employing Department should forward duplicate copy to Workers' Compensation Division of Law Department.

DP 2002 (revised 10/15)

Reset Form

THE CITY OF NEW YORK
WORKERS' COMPENSATION CLAIM INITIATION
WITNESS STATEMENT

FISA FORM WCS-120 (8/00)

CLAIM NUMBER

INJURED EMPLOYEE NAME

FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

WITNESS INFORMATION

FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

STREET LOCATION (INCLUDE APT / FL #)

HOME ADDRESS

BORO, CITY OR TOWN | STATE | ZIP | PLUS 4

WORK TEL # (AREA CD)

HOME TEL# (AREA CD)

ARE YOU A CITY EMPLOYEE? ☐ YES ☐ NO

RELATIONSHIP TO INJURED

DATE OF ACCIDENT / INJURY — MONTH / DAY / YEAR

TIME OF ACCIDENT — HOUR : MINUTE ☐ AM ☐ PM

LIST OTHER PERSONS WHO ALSO MIGHT HAVE WITNESSED ACCIDENT

ATTACH NAMES OF ADDITIONAL WITNESSES

☐ *CONTINUATION ATTACHED*

FIRST NAME	M.I.	LAST NAME

DESCRIPTION OF ACCIDENT - INCLUDING LOCATION

☐ *CONTINUATION ATTACHED*

NAME (PLEASE PRINT) | TITLE | TEL.#

SIGNATURE | DATE

THE CITY OF NEW YORK - WORKERS' COMPENSATION CLAIM INITIATION

Supervisor's/Agency - "REPORT OF INJURY"

Reset Form | Validate Form

FISA FORM WCS-100 (4/09) (CONTINUED ON REVERSE SIDE)

CLAIM NUMBER

INJURED EMPLOYEE NAME

FIRST NAME | M.I. | LAST NAME | EMPLOYEE ID

EMPLOYEE'S ADDRESS

STREET LOCATION | APT #, FL.#, BOX #

BORO, CITY OR TOWN | STATE | ZIP

DATE OF ACCIDENT / INJURY (MONTH / DAY / YEAR)

TIME OF ACCIDENT (HOUR : MINUTE) AM PM

WAS EMPLOYEE ABSENT DUE TO INJURY? YES NO

INITIAL ABSENCE DATE (MONTH / DAY / YEAR)

INITIAL ABSENCE TIME (HOUR : MINUTE) AM PM

TIME EMPLOYEE BEGAN WORK (HOUR : MINUTE) AM PM

IS EMPLOYEE EXPECTED TO RETURN TO WORK? YES NO

INJURED WORKER'S WORK WEEK: SUN MON TUE WED THU FRI SAT

(ENTER AN "X" FOR DAYS USUALLY WORKED)

HAS EMPLOYEE RETURNED TO WORK? YES NO

RETURN TO WORK DATE (MONTH / DAY / YEAR)

WAS EMPLOYEE PAID FOR A FULL DAY ON THE DAY OF THE INJURY/ILLNESS? YES NO

HAS THE EMPLOYEE GIVEN YOU NOTICE OF INJURY/ILLNESS? YES NO

IF YES, NOTICE WAS GIVEN TO: ORALLY IN WRITING

DATE NOTICE PROVIDED (MONTH / DAY / YEAR)

SUPERVISOR'S

FIRST NAME | M.I. | LAST NAME

TITLE | (AREA CD) | WORK TELEPHONE # | EXTENSION

WAS ACCIDENT ON EMPLOYER'S PREMISES? YES NO

DID ACCIDENT OCCUR DURING WORK HOURS? YES NO

DID ACCIDENT OCCUR DURING LUNCH BREAK? YES NO

WAS EMPLOYEE TRAVELING TO/FROM WORK? YES NO

WAS EMPLOYEE TRAVELING BETWEEN WORK SITES? YES NO

DID ACCIDENT OCCUR AT NORMAL WORK SITE LOCATION? YES NO

IF NO, EXACT LOCATION AND COUNTY OF ACCIDENT REQUIRED

IF ACCIDENT DID NOT OCCUR AT NORMAL WORK SITE, AN EXPLANATION OF WHY EMPLOYEE WAS AT ACCIDENT SITE IS REQUIRED

WAS EMPLOYEE ON SPECIAL OR WORK RELATED FIELD ASSIGNMENT? YES NO

IF YES, DESCRIBE FIELD ASSIGNMENT

CONTINUATION #1 ATTACHED

WAS INJURY WITNESSED BY SUPERVISOR? YES NO *INJURY DESCRIPTION AS WITNESSED BY SUPERVISOR OR AS REPORTED MUST BE PROVIDED BELOW*

CONTINUATION #2 ATTACHED

DID EMPLOYEE FOLLOW STANDARD PROCEDURES AT TIME OF ACCIDENT? YES NO

IF NO, DETAILS REQUIRED

CONTINUATION #3 ATTACHED

DID EMPLOYEE'S ACTION OR BEHAVIOR CONTRIBUTE TO THE ACCIDENT? YES NO

IF YES, DETAILS REQUIRED

CONTINUATION #4 ATTACHED

ARE DISCIPLINARY ACTIONS PENDING OR CONSIDERED AGAINST EMPLOYEE? YES NO

IF YES, DETAILS REQUIRED

CONTINUATION #5 ATTACHED

DOES THE AGENCY RECOMMEND TO CONTROVERT? YES NO

IF YES, DETAILS REQUIRED

CONTINUATION #6 ATTACHED

ARE YOU AWARE OF PRE-EXISTING CONDITIONS? YES NO

IF YES, EXPLAIN CONDITION(S)

CONTINUATION #7 ATTACHED

WHAT WAS THE DATE OF EMPLOYEE'S FIRST TREATMENT? (MONTH / DAY / YEAR) NONE RECEIVED UNKNOWN

WHERE DID THE EMPLOYEE RECEIVE FIRST MEDICAL TREATMENT FOR THIS INJURY/ILLNESS? ON SITE DOCTOR'S OFFICE EMERGENCY ROOM CHILD/ HOSPITAL/ URGENT CARE HOSPITAL STAY OVER 24 HOURS UNKNOWN

WHO TREATED THE EMPLOYEE AND WHERE?

IS THE EMPLOYEE STILL BEING TREATED FOR THIS INJURY/ILLNESS? YES NO

IF YES, PLEASE ENTER THE NAME AND ADDRESS OF TREATING DOCTOR(S) IN THE DOCTOR SECTION BELOW.

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):

DOCTOR

NAME: FIRST | M.I. | LAST

ADDRESS: STREET LOCATION

BORO, CITY OR TOWN | STATE | ZIP | PLUS 4

DOCTOR

NAME: FIRST | M.I. | LAST

ADDRESS: STREET LOCATION

BORO, CITY OR TOWN | STATE | ZIP | PLUS 4

ADDITIONAL INFORMATION: _____

WAS AN OBJECT (E.G HAMMER, ACID) INVOLVED IN THE INJURY/ILLNESS? ☐ YES ☐ NO

IF YES, WHAT WAS IT? _____

INJURY DESCRIPTION *(SEE CODE TABLE FOR DETAILED INJURY, CAUSE & BODY PART DESCRIPTION CODE BREAKDOWN*

NATURE OF INJURY	INJURY TYPE	INJURY CODE	DESCRIPTION
	SI ☐ SPECIFIC INJURY ☐ OD OCCUPATIONAL DISEASE	☐☐	

☐ *CONTINUATION #8 ATTACHED*

CAUSE OF ACCIDENT — CAUSE CODE ☐☐

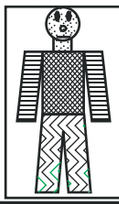
CAUSE TYPE (CHECK ONE): ☐ EXPOSURE(EX) ☐ FALL/SLIP(FS) ☐ STRIKING AGAINST/STEP ON(SA) ☐ CAUGHT BETWEEN(CB) ☐ MOTOR VEHICLE(MV) ☐ STRUCK/INJURED(SK) ☐ CUT/PUNCTURE(CP) ☐ STRAIN/INJURED (SN) ☐ MISCELLANEOUS CAUSE(MS)

DESCRIPTION

☐ *CONTINUATION #9 ATTACHED*

BODY PART(S) AFFECTED

(INDICATE INJURED BODY PART CODE, DESCRIPTION AND SIDE(S) AFFECTED, IF APPLICABLE)



BODY SECTION CODES: HN (HEAD/NECK), UE (UPPER), TR (TRUNK), LE (LOWER)

BODY SECTION ☐☐ / PART CODE ☐☐	DESCRIPTION: ☐ LEFT ☐ RIGHT ☐ BOTH	BODY SECTION ☐☐ / PART CODE ☐☐	DESCRIPTION: ☐ LEFT ☐ RIGHT ☐ BOTH	BODY SECTION ☐☐ / PART CODE ☐☐	DESCRIPTION: ☐ LEFT ☐ RIGHT ☐ BOTH
BODY SECTION ☐☐ / PART CODE ☐☐	DESCRIPTION: ☐ LEFT ☐ RIGHT ☐ BOTH	BODY SECTION ☐☐ / PART CODE ☐☐	DESCRIPTION: ☐ LEFT ☐ RIGHT ☐ BOTH	BODY SECTION ☐☐ / PART CODE ☐☐	DESCRIPTION: ☐ LEFT ☐ RIGHT ☐ BOTH

EMPLOYEE'S JOB DESCRIPTION

JOB TASK AT TIME OF INJURY — FUNCTIONAL TITLE & DESCRIPTION (ATTACH JOB DESCRIPTION IF AVAILABLE)

EMPLOYEE'S JOB WAS (CHECK ONE): ☐ FULL TIME ☐ PART TIME

TYPICAL WORKDAY (8 HR. MAX.)

SITTING		STANDING		WALKING	
HOUR	MINUTE	HOUR	MINUTE	HOUR	MINUTE
☐☐ :	☐☐	☐☐ :	☐☐	☐☐ :	☐☐

TYPICAL WORKDAY TASKS / INDICATE WORKDAY ACTIVITY %

ACTIVITY	0 % (N / A)	10 % (MINIMAL)	20 % (OCCASIONAL)	35 % (MODERATE)	50 % (FREQUENT)	70 - 100 % (CONTINUOUS)
BENDING / SQUATTING	A	B	C	D	E	F
CLIMBING	A	B	C	D	E	F
KNEELING	A	B	C	D	E	F
LIFTING * *Complete Lifting Detail Section*	A	B	C	D	E	F
REACHING ABOVE SHOULDER	A	B	C	D	E	F
PUSH / PULL	A	B	C	D	E	F

LIFTING DETAILS

*LIFTING	0 % (N / A)	10 % (MINIMAL)	20 % (OCCASIONAL)	35 % (MODERATE)	50 % (FREQUENT)	70 - 100 % (CONTINUOUS)
UP TO 10 POUNDS	A	B	C	D	E	F
11 TO 20 POUNDS	A	B	C	D	E	F
21 TO 30 POUNDS	A	B	C	D	E	F
31 TO 50 POUNDS	A	B	C	D	E	F
OVER 50 POUNDS	A	B	C	D	E	F

INDICATE THE PERCENTAGE OF WEIGHT LIFTED PER CATEGORY DURING A TYPICAL WORKDAY

IS KEYBOARD USED? YES ☐ NO ☐ IF YES, HOW MANY HRS PER WEEK? ☐☐

ARE HANDS USED FOR NON KEYBOARD REPETITIVE MOTION? YES ☐ NO ☐ IF YES, EXPLAIN WHAT OTHER REPETITIVE MOTIONS ARE PERFORMED? _____

IS CLAIMANT A SEASONAL EMPLOYEE? ☐ YES ☐ NO

DID ACCIDENT INVOLVE A MOTOR VEHICLE? ☐ YES ☐ NO IF YES, WAS VEHICLE REGISTERED TO THE CITY OF NEW YORK? YES ☐ NO ☐ USE OF CITY VEHICLE AUTHORIZED? YES ☐ NO ☐ EMPLOYEE STRUCK BY CITY VEHICLE? YES ☐ NO ☐ EMPLOYEE DRIVING A CITY VEHICLE? YES ☐ NO ☐

WAS INJURED ON PUBLIC TRANSPORTATION? YES ☐ NO ☐ IF YES, EXPLAIN DOES EMPLOYEE OWN THE VEHICLE? YES ☐ NO ☐

☐ *CONTINUATION #12 ATTACHED*

WAS EMPLOYEE A VEHICLE PASSENGER? YES ☐ NO ☐

DID EMPLOYEE DIE FROM INJURY? YES ☐ NO ☐ *IF YES, ANSWER THE FOLLOWING QUESTIONS*

DATE EMPLOYEE DIED: MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐☐☐ TIME EMPLOYEE DIED: HOUR ☐☐ : MINUTE ☐☐ AM ☐ PM ☐

NAME OF NEAREST RELATIVE — FIRST _____ M.I. ☐ LAST NAME _____

RELATIONSHIP _____ HOME TELEPHONE # ☐☐☐ ☐☐☐-☐☐☐☐

ADDRESS — STREET LOCATION (INCLUDE APT/FL#) _____

BORO, CITY OR TOWN _____ STATE ☐☐ ZIP ☐☐☐☐☐ PLUS 4 ☐☐☐☐

IDENTIFY PERTINENT DOCUMENTATION (e.g. Police Report, Safety Reports, etc.) _____

☐ *CONTINUATION #10 ATTACHED*

WAS INJURY CAUSED BY ASSAULT ON THE JOB? ☐ YES ☐ NO *IF YES, PROVIDE INFORMATION BELOW*

ASSAILANT WAS: ☐ CO - WORKER ☐ FRIEND, FAMILY OR ACQUAINTANCE ☐ CLIENT ☐ OTHER _____ ☐ OFFENDER ☐ OWNER / OPERATOR ☐ OUTSIDE CONTRACTOR

ASSAULTED BY

NAME OF ASSAILANT — FIRST _____ M.I. ☐ LAST NAME _____

ADDRESS — STREET LOCATION (INCLUDE APT/FL#) _____

BORO, CITY OR TOWN _____ STATE ☐☐ ZIP ☐☐☐☐☐ PLUS 4 ☐☐☐☐

HOME TELEPHONE # ☐☐☐ ☐☐☐-☐☐☐☐ WORK TELEPHONE # ☐☐☐ ☐☐☐-☐☐☐☐ EXTENSION ☐☐☐☐

CAN YOU PROVIDE DETAILED EVENTS PRECEDING ASSAULT? ☐ YES ☐ NO IF YES, EXPLAIN _____

☐ *CONTINUATION #11 ATTACHED*

DID ASSAULT INVOLVE A PERSONAL MATTER? ☐ YES ☐ NO IF YES, EXPLAIN _____

☐ *CONTINUATION #12 ATTACHED*

DID ASSAULT INVOLVE WORK RELATED MATTER? ☐ YES ☐ NO IF YES, EXPLAIN _____

☐ *CONTINUATION #13 ATTACHED*

DID THE EMPLOYEE START, PROVOKE OR PROLONG THE ASSAULT IN ANY WAY? ☐ YES ☐ NO IF YES, EXPLAIN _____

☐ *CONTINUATION #14 ATTACHED*

PREPARED BY (Please Print)	TITLE
SIGNATURE	TEL # / DATE

THE CITY OF NEW YORK
WORKERS' COMPENSATION CLAIM INITIATION

ACCIDENT DESCRIPTION CODES

FIS-A FORM WCS-1 OOC (5/00)

NATURE OF INJURY

SI SPECIFIC INJURY

02 AMPUTATION	16 DISLOCATION	30 FREEZING	40 LACERATION (CUT)	49 SPRAIN
03 ANGINA PECTORIS (Chest Pains)	19 ELECTRIC SHOCK	31 HEARING LOSS, TRAUMATIC	41 MYOCARDIAL INFARCTION (Heart Attack)	52 STRAIN
04 BURN	22 ENUCLEATION (To Remove Eye Tumor, Etc)	32 HEAT PROSTRATION		54 ASPHYXIATION
07 CONCUSSION		34 HERNIA	43 PUNCTURE	55 VASCULAR LOSS
10 CONTUSION	25 FOREIGN BODY	36 INFECTION	46 RUPTURE	58 VISION LOSS
13 CRUSHING	28 FRACTURE	37 INFLAMMATION	47 SEVERANCE (CUT OFF)	59 ALL OTHER

OD Occupation Disease

60 DUST DISEASE	64 SILICOSIS	68 DERMATITIS	72 HEARING LOSS (Non-Traumatic)	76 VDT RELATED DISEASE
61 ASBESTOSIS	65 RESPIRATORY DISORDERS (Gas, Fumes etc)	69 MENTAL DISORDER	73 CONTAGIOUS DISEASE	77 MENTAL STRESS
62 BLACK LUNG	66 POISONING - CHEMICAL	70 RADIATION	74 CANCER	78 CARPAL TUNNEL SYNDROME
63 BYSSINOSIS	67 POISONING - METAL	71 ALL OTHER OCCUPATIONAL DISEASE	75 AIDS	80 ALL OTHER CUMULATIVE INJURIES

CAUSE OF ACCIDENT

EX EXPOSURE
01 ACID OR CHEMICALS
02 CONTACT WITH HOT OBJECT
03 TEMPERATURE EXTREMES
04 FIRE OR FLAME
05 STEAM OR HOT FLUID
06 DUST/GASSES/FUMES/VAPORS
07 WELDING OPERATION
08 RADIATION
09 MISCELLANEOUS

CB CAUGHT IN OR BETWEEN
10 MACHINE OR MACHINERY
12 OBJECT HANDLED
13 MISCELLANEOUS

CP CUT/PUNCTURE
15 BROKEN GLASS
16 HAND TOOL/UTENSIL (NONPOWERED)
18 POWERED HAND TOOL/APPLIANCE
19 MISCELLANEOUS

FS FALL OR SLIP
25 FROM DIFFERENT LEVEL
26 FROM LADDER OR SCAFFOLD
27 ON LIQUID OR GREASE SPILL
29 ON SAME LEVEL
30 SLIPPED, WITHOUT FALLING
31 MISCELLANEOUS

MV MOTOR VEHICLE
45 COLLISION WITH OTHER VEHICLE
46 COLLISION WITH FIXED OBJECT
47 CRASH OF AIRPLANE
48 VEHICLE UPSET
50 MISCELLANEOUS

SN STRAIN OR INJURY
54 JUMPING
55 HOLDING OR CARRYING
56 LIFTING
57 PUSHING OR PULLING
58 REACHING
59 USING TOOL OR MACHINERY
60 MISCELLANEOUS

SA STRIKING AGAINST OR STEPPING ON
65 MOVING PART(S) OF MACHINERY
66 OBJECT BEING LIFTED/HANDLED
67 SAND, SCRAP OR CLEANING OPERATION
68 STATIONARY OBJECT
69 STEPPING ON SHARP OBJECT
70 MISCELLANEOUS

SK STRUCK OR INJURED BY
75 FALLING/FLYING OBJECT
76 HAND TOOL/MACHINE IN USE
77 MOTOR VEHICLE
78 MOVING PART(S) OF MACHINE
79 OBJECT BEING LIFTED/HANDLED
80 OBJECT HANDLED BY OTHERS
81 MISCELLANEOUS

MS MISCELLANEOUS CAUSES
84 ELECTRIC CURRENT CONTACT
85 ANIMAL OR INSECT
86 EXPLOSION OR FLARE BACK
87 FOREIGN BODY IN EYE
89 ROBBERY/CRIMINAL ASSAULT
97 REPETITIVE MOTION
98 CUMULATIVE (ALL OTHER)
99 OTHER

BODY PART(S) AFFECTED

HN HEAD
10 MULTIPLE HEAD INJURIES
11 SKULL
12 BRAIN
13 EAR (LEFT, RIGHT OR BOTH)
14 EYE (LEFT, RIGHT OR BOTH)
15 NOSE
16 TEETH
17 MOUTH
18 OTHER SOFT FACIAL TISSUE
19 FACIAL BONES

HN NECK
20 MULTIPLE NECK INJURIES
21 VERTEBRAE (NECK BONES)
22 DISC
23 SPINAL CORD
24 LARYNX (VOICE BOX)
25 SOFT TISSUE
26 TRACHEA (WIND PIPE)

UE UPPER EXTREMITIES
30 MULTIPLE INJURIES
31 UPPER ARM - INCLUDING SHOULDER (LEFT, RIGHT OR BOTH)
32 ELBOW (LEFT, RIGHT OR BOTH)
33 LOWER ARM (LEFT, RIGHT OR BOTH)
34 WRIST (LEFT, RIGHT OR BOTH)
35 HAND (LEFT, RIGHT OR BOTH)
36 FINGER(S) (LEFT, RIGHT OR BOTH)
37 THUMB (LEFT, RIGHT OR BOTH)

TR TRUNK
40 MULTIPLE TRUNK
41 UPPER BACK AREA
42 LOWER BACK AREA
43 DISC
44 CHEST (RIBS, BREAST BONE, TISSUE)
45 SACRUM/COCCYX, BUTTOCKS
46 PELVIS
47 SPINAL CORD
48 INTERNAL ORGAN
49 HEART

LE LOWER EXTREMITIES
50 MULTI INJURIES (LEFT, RIGHT OR BTH)
51 HIP (LEFT, RIGHT OR BOTH)
52 THIGH (LEFT, RIGHT OR BOTH)
53 KNEE (LEFT, RIGHT OR BOTH)
54 LOWER LEG (LEFT, RIGHT OR BOTH)
55 ANKLE (LEFT, RIGHT OR BOTH)
56 FOOT (LEFT, RIGHT OR BOTH)
57 TOE(S) (LEFT, RIGHT OR BOTH)