

**STATE OF NEW YORK  
WORKERS' COMPENSATION BOARD  
EMPLOYER'S REPORT OF INJURY/ILLNESS**

File directly to Chairman, Workers' Compensation Board at address shown on reverse side within ten (10) days if accident occurs. Answer all questions fully. Copy also should be sent to your insurance carrier. This form replaces all previous versions of Forms C-2 and C-2.5.

PLEASE PRINT OR TYPE—INCLUDE ZIP CODE IN ALL ADDRESSES—EMPLOYEE'S S.S. NO. MUST BE ENTERED BELOW

WCB CASE NO. (If Known)	CARRIER CASE NO.	CODE NO. <b>W204002</b>	WC POLICY NUMBER	DATE OF ACCIDENT	EMPLOYEE'S S.S. NO.
1.(a) EMPLOYER'S NAME		(b) EMPLOYER'S MAILING ADDRESS		(c) OSHA CASE/FILE NO.	
(d) LOCATION (If different from mail address)		(e) NATURE OF BUSINESS (Principal products, services, etc.)		(f) NYS U.I. Employer Reg. No.	
2. (a) INSURANCE CARRIER <b>THE STATE INSURANCE FUND</b>			(b) CARRIER'S ADDRESS <b>199 Church Street, New York, NY 10007</b>		
3. (a) INJURED PERSON (FIRST, M.I., LAST)			(b) ADDRESS (Include No. & Street, City, State, Zip & Apt. No.)		
ACCIDENT	4. ADDRESS WHERE ACCIDENT OCCURRED		COUNTY		WAS ACCIDENT ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO
	5. TIME OF ACCIDENT AM _____ PM _____	6. DEPT. WHERE REGULARLY EMPLOYED	7.(a) DATE STOPPED WORK BECAUSE OF THIS INJURY/ILLNESS		(b) WAS INJURED PAID IN FULL FOR DAY? <input type="checkbox"/> YES <input type="checkbox"/> NO
PERSON	8. SEX	9. AGE	10. OCCUPATION (Specific job title at which employed).		
	11.(a) AVERAGE EARNINGS PER WEEK?		(b) TOTAL EARNINGS PAID DURING 52 WEEKS PRIOR TO DATE OF ACCIDENT (Include bonuses, overtime, value of lodging, etc.)		
INJURY	12.(a) PART OR FULL TIME WORKER?		(b) INJURED WORKER'S WORK WEEK (Indicate days of week usually worked).		
	13. NATURE OF INJURY AND PART(S) OF BODY AFFECTED		14. DID YOU PROVIDE MEDICAL CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHEN?
OF	15.(a) NAME AND ADDRESS OF DOCTOR		(b) NAME AND ADDRESS OF HOSPITAL		
	16. HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, DATE		AT WHAT WEEKLY WAGE?
<b>NOTE: FORM C-11 MUST BE FILED EACH TIME THERE IS A CHANGE IN EMPLOYMENT STATUS</b>					
CAUSE OF ACCIDENT	17. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.)				
	18. 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.)				
	19. 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	20. DATE OF DEATH	NAME/ADDRESS OF NEAREST RELATIVE			RELATIONSHIP

DATE OF THIS REPORT \_\_\_\_\_

SIGNED BY \_\_\_\_\_

DATE YOU OR SUPERVISOR FIRST KNEW OF INJURY \_\_\_\_\_

OFFICIAL TITLE \_\_\_\_\_

CHECK BOX IF PREVIOUSLY REPORTED ON FORM C-2.1.

AREA CODE, TEL. NO. & EXT. \_\_\_\_\_

THE WORKERS' COMPENSATION BOARD EMPLOYERS AND SERVES THE HANDICAPPED WITHOUT DISCRIMINATION.

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