

NEW YORK STATE
WORKERS' COMPENSATION BOARD

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

Send this notice directly to Chair, Workers' Compensation Board at address shown on reverse side within ten (10) days after accident occurs. Answer all questions fully. Copy should also be sent to your workers' compensation insurance carrier. This form replaces all previous versions of Form C-2.

Failure to timely file Form C-2, as required by Section 110 of the Workers' Compensation Law, may subject the employer to a penalty of up to \$2,5000.

ANSWER ALL QUESTIONS FULLY

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

WCB CASE NO. (If Known)	CARRIER CASE NO.	CODE NO. W204002	WC POLICY NUMBER	DATE OF ACCIDENT	EMPLOYEE'S S.S. NO.	
1. (a) EMPLOYER'S NAME		(b) EMPLOYER' 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 THE STATE INSURANCE FUND			(b) CARRIER'S ADDRESS 199 Church Street, New York, NY 10007			
3. (a) INJURED PERSON (First, M.I., Last)			(b) ADDRESS (Includes No. & Street, City, State, Zip & Apt. No.)			
ACCIDENT	4. (a) ADDRESS WHERE ACCIDENT OCCURRED		(b) COUNTY		(c) 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	
INJURED PERSON	8. SEX		9. AGE		10. OCCUPATION (Specific job title at which employed).	
	11. (a) AVERAGE EARNINGS PER WORKER?		(b) TOTAL EARNINGS PAID DURING WEEKS PRIOR TO DATE OF ACCIDENT (Include bonuses, overtime, value of lodging, etc).			
	12. (a) PART OR FULL TIME WORKER?		(b) INJURED WORKER'S WORK WEEK (Include days of week usually worked).			
NATURE OF INJURY	13. NATURE OF INJURY AND PART(S) OF BODY AFFECTED		14. (a) DID YOU PROVIDE MEDICAL CARE? <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) IF YES, WHEN?	
	15. (A) NAME AND ADDRESS OF DOCTOR		(b) NAME AND ADDRESS OF HOSPITAL			
	16. (a) HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) IF YES, DATE		(c) AT WHAT WEEKLY WAGE?	
CAUSE OF ACCIDENT	NOTE: FORM C-11 MUST BE FILED EACH TIME THERE IS A CHANGE IN EMPLOYMENT STATUS					
	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 strain, the thing(s) he was lifting, pulling, etc.						
FATAL CASES	20. (a) DATE OF DEATH	(b) NAME/ADDRESS OF NEAREST RELATIVE			(c) 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.
--	---

TEL. NO. & EXT. _____

THE WORKERS COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.