New York City Transit

Department of Subways
Injury on Duty (IOD) Information

Step 1

Report IOD within 24 hours

- **RTO:** Contact RCC
- **Stations:** Contact RCC
- **DCE:** Contact Emergency Response
- **MOW:** Contact MOW Control
- **EMD:** Contact EMD Command Center

Step 2

Submit IOD package within 48 hours

- IOD form
- Waiver & Election form
- IOD Management Follow-Up form
- Management Team's Memo

Step 3

Submit medical forms on day of IME/PMD appointment

- **RTO:** Employees report to IOD Unit
- **Stations:** Employees report to IOD Unit
- **DCE:** Employees report to work location
- **MOW:** Employees report to work location
- **EMD:** Employees report to work location

DCE & MOW/EMD
Field must forward medical forms to IOD Unit

Contact Information

Department	Phone Number	Fax Number
IOD Unit	718-694-5725	718-694-1205
RCC	IRT: 718-243-4111 IND: 718-243-4211 BMT: 718-243-4311 Stations: 212-712-4236	RTO: 212-712-4750 Stations: 212-712-4753
Emergency Response	212-712-4243 800-233-4377	212-712-4752
MOW Control	212-712-4120	212-712-4278
EMD Command Center	718-243-4506	718-694-4334

New York City Transit

Department of Subways
Injury on Duty (IOD) Information

With any Injury on Duty-related questions, please contact the IOD Unit at 718-694-5725 or email SubwaysIOD@nyct.com.

Items to Note:

IOD Form: The following are critical steps to perform when completing the IOD form.

- **Describe Injury:** detail the date, time and location of injury, how it occurred and the type of injury (page 1). When employees report an injury, management/supervision must give them an IOD package. Each injury, even if it is a recurrence to a prior injury, must be reported and new IOD documents must be submitted.
  - **Recurrences:** A recurrence is an injury that is experienced after the employee returns to work and is caused by or related to a previously reported IOD.

Steps to Report Recurrences	
1. Report Recurrence	Report injury as a recurrence to RCC, Emergency Response or MOW Control
2. Complete new IOD package	IOD form: Indicate date of recurrence injury and date of original/prior injury
	Recurrence date & original/prior injury date cannot be the same
3. Describe Injury	Explain what employee was doing at the time of recurrence; not original injury
4. Scheduled Surgery	A. If surgery is required for IOD, submit new IOD package with medical forms and indicate surgery as a recurrence in advance.
	B. Same day employee goes out for surgery, management/supervision calls RCC, DCE Emergency Response, MOW Control to report surgery as a recurrence.
5. Recurrence at Work	If employee has recurrence at work, Management Follow-Up form is required
6. Recurrence at Home	If employee has recurrence at home, root cause for injury is "recurrence"

- **Injury Information:** If management/supervision does not observe the injury, s/he must describe what was told to them about how the injury occurred on the IOD form (page 3).
- **Fact-Finding:** If anyone observed, spoke with, or assisted the injured employee, management/supervision must list the names of those individuals on the IOD form (page 4).
- **Root Cause Analysis & Recommendations:** Management/supervision must identify root causes of injuries and give recommendations to prevent similar injuries on the IOD form (page 4). "Unsubstantiated" or "not witnessed" are not acceptable answers.
  - Root Cause Examples: Assault, Chemical Contact/Inhalation, Defective Equipment, Fatigue, Human Accident, Improper Procedure/Tools, Inattention, Inclement Weather, Lack of Maintenance/ Training, etc.
- **Differential Application:** All employees must sign & date Differential Application on the IOD form (page 2).
  - Only the employee can sign this section. If employee is unable to sign, s/he must submit a copy of the original IOD form with a signed Differential Application or report to the IOD Unit as soon as possible.
- **Waiver & Election:** Employees must indicate Waiver & Election preferences on the IOD form (page 2).
  - Employees may use accrued sick and/or vacation leave on the first day after the IOD for payment up to a maximum 20 days while Workers' Compensation claims are reviewed.
  - If employees request Waiver & Election payments, a Waiver & Election form must be submitted with the IOD form. Employees must check the box to indicate whether payments should be drawn from sick leave, vacation time or both.
  - Employees must submit medical documentation pursuant to Workers' Compensation Law and certify absences through the IOD medical form.

Telephonic #	ON THE JOB INJURY FORM page 1 of 4	Report Date ____/____/____

Department must call in employee injury within 24 hours of injury (1-888-682-4301)

Injured Employee	1. Complete PART A - Employee Section and Differential Application upon occurrence of injury or recurrence of injury on duty 2. Make three (3) photocopies and keep one (1) copy
Supervisor	1. Complete PART A - Employee Section if employee is not available 2. Complete PART B - Department Section 3. Fax form within 24 hours to Workers' Comp Unit (718-694-3281/3807) 4. Send original form within 2 business days to Workers' Comp Unit, 130 Livingston, 10th fl. 5. *Department of Subways only* - Send form within 2 business days to IOD Unit, 130 Livingston, 6th fl. 6. *Department of Buses only* – Send form within 2 business days to DOB Safety, 25 Jamaica Avenue, Rm. 28H

PLEASE PRINT – FULLY ANSWER ALL QUESTIONS

EMPLOYEE'S AGENCY: MTA ☐ **NYCTA** ☐ **MABSTOA** ☐ **SIRTOA** ☐ **UNION AFFILIATION:** _____

PART A - EMPLOYEE SECTION

(if employee is not available, Supervisor must complete this section and sign form)

Name: Last _____ First _____ M.I. _____

Pass# _____ BSC# _____ Date of Birth ___/___/____ Soc. Sec.# XXX–XX–____

Home Address (& Apt. #) _____ City _____ State _____

Zip Code _____ Gender (M/F) ____ Home Phone # _____ Cell Phone # _____

Home Email Address _____ Job Title _____ Title Code _____ Date of Hire ___/___/____

Dept./Division _____ RCN # _____ Work Location _____

Name of Supervisor _____ Total Hrs. Worked 7 Days Prior to Injury _____

Work Status at Time of Injury: Full ☐ Restricted ☐ Tour / Hrs. of Duty: From _____ (AM/PM) To _____ (AM/PM)

Wages/Hr: _____ Scheduled Lunch: From _____ (AM/PM) To _____ (AM/PM) RDOs _____

DESCRIBE INJURY:

Date of injury ____/____/____ Time of day employee began work on date of injury: _____ (AM/PM)

Time of injury: _____ (AM/PM) Date of Death (*if applicable*) ___/___/____

Recurrence of Prior Injury? Y ☐ N ☐ Date of Prior Injury ____/____/____

Location of Injury: County _____

☐ Train: # _____ Yard _____ Tower _____ Track # _____ Station _____ Shop _____

☐ Bus: # _____ Depot _____ Storeroom #_____ Street _____ Vehicle #_____

☐ Other: (*give exact address*) _____

Telephonic #	ON THE JOB INJURY FORM page 2 of 4	Report Date TY - data zgloszenia

TY - imie i nazwisko poszkodowanego

TY - Pass#

Injured Employee's Name _____ *Pass#* _____

Describe in detail how the injury occurred. Indicate what you were doing at the time of the incident. Name the object, substance or condition which directly caused the injury. (*Attach an additional sheet(s) if necessary*)

TY - opisz co sie stalo, gdy dojdzie do urazu (wypelnij w razie zdarzenia)

Type of Injury (*burn, cut, fracture*) _____

Body part(s) affected (*right leg, left arm, head*) _____

Medical Treatment Requested? Y ☐ N ☐ Date Notified Supervisor: ___/___/____

Received Workers' Comp Statement of Rights? Y ☐ N ☐

Received Injury on Duty Instruction Sheet? Y ☐ N ☐

I declare under penalty of perjury, under the laws of the State of New York, that all statements contained in this On-the-Job-Injury form and any accompanying documents are true and correct, with full knowledge that all statements made herein are subject to investigation and that any false or dishonest answer to any question may be grounds for disciplinary action.

Employee Signature: _____ Date ___/___/____

Supervisor Signature: _____ Date ___/___/____
(if employee fails to sign)

FAMILY MEDICAL LEAVE ACT (FMLA)

Please be advised that in the event of a lost time injury greater than 30 days, lost time relating to the on-the- job injury will be designated as leave usage under the Family Medical Leave Act (FMLA) if you are otherwise eligible. This notice does not constitute a waiver of any right that the Transit Authority has to controvert the claimed on-the-job injury.

DIFFERENTIAL APPLICATION

Employee must sign Differential Application to begin processing. Signature does not denote agreement with Supervisor's Report nor Workers' Compensation determinations of eligibility. I understand that, in making this application for Differential Benefit, I have agreed that the Authority may seek to recoup the value of Differential Benefits paid from any judgment or settlement of an action against third parties I may institute as a result of this Injury. I hereby apply for payment of differential.

Employee's Name (please print) _____

Employee's Signature: _____ Date ___/___/____

WAIVER & ELECTION

Requesting Waiver & Election? Y ☐ N ☐ If yes, Employee must complete Waiver & Election Form, and Department must submit the form within 2 business days.

Telephonic #	ON THE JOB INJURY FORM	Report Date
_____	page 3 of 4	____/____/____

PART B - DEPARTMENT SECTION

(Supervisor must complete this section and sign form)

Injured Employee's Name _____ *Pass#* _____

Supervisor's Name: Last _____ First _____ M.I. ____

Pass# _____ BSC# _____ Work Location _____

Work Phone Number _____ Cell Phone Number _____

INJURY INFORMATION

Did you observe the injury? Y☐ N☐ If no, Who reported the injury to you? _____

Describe in detail your knowledge of how the injury occurred. (*Attach an additional sheet(s) if necessary*)

_____

_____

_____

At the time of the injury was the employee performing job-related assigned duties? Y☐ N☐ Unknown ☐

Was the employee working approved overtime? Y☐ N☐ Unknown☐

Did the employee appear fit for duty? Y☐ N☐ Unknown☐ If not, explain: _____

Did the employee stop working? Y☐ N☐ Date Stopped Work: ___/___/____

Has the employee returned to work? Y☐ N☐ Return to work date: ___/___/____

Date the employee reported to MAC for Drug/Alcohol Testing: ___/___/____

RESPONSE TO INJURY

Was first aid given? Y☐ N☐ If yes, describe the type of first aid: _____

Who was first at the injury scene? Name: _____ Phone Number _____

Area secured/immediate hazard eliminated?

Y☐ Time: _____ (AM/PM) N☐ If not, why? _____

If treatment given away from worksite, where was it given? Name of Facility _____

Address _____ City _____ State _____ Zip Code _____

Was the employee transported by ambulance? Y☐ N☐ Treated in E/R? Y☐ N☐ Hospitalized? Y☐ N☐

Name of doctor or health care professional: _____ Badge # (*if applicable*) _____

Telephonic #	ON THE JOB INJURY FORM page 4 of 4	Report Date
_____		____/____/____

Injured Employee's Name _____ *Pass#* _____

FACT-FINDING

Did you speak to the injured employee? Y☐ N☐ If yes, Date: ___/___/____

Did anyone observe the injury or speak to or assist the employee? Y☐ N☐ Unknown☐ If yes, List:

Name _____ Title _____ Pass# _____ Phone # _____

Name _____ Title _____ Pass# _____ Phone # _____

Name _____ Title _____ Pass# _____ Phone # _____

☐Photograph ☐Sketch ☐Video If checked, by whom? Name: _____ Date: ___/___/____

ROOT CAUSE ANALYSIS: (Why did it happen? What actually caused the injury or incident?)

Was an object (e.g., equipment, tool) involved in the injury? Y☐ N☐ If yes, what?_____

Was the equipment/tool defective or used improperly? Y☐ N☐ If yes, explain _____

Was a chemical or air contaminant involved? Y☐ N☐ If yes, what? _____

Did the employee follow the policies or procedures for the tasks being performed at the time of the injury? Y☐ N☐

If no, please explain _____

Did the employee receive required training? Y☐ N☐ Unknown☐

Was required Personal Protective Equipment (PPE) used? Y☐ N☐

Did the employee's actions (e.g., horseplay, distracted, drug or alcohol use) contribute to the injury? Y☐ N☐

If yes, please explain _____

Were there any conditions (e.g., poor housekeeping, insufficient lighting, weather (snow, rain, heat, cold), defects in walking/working surface) that contributed to the injury? Y☐ N☐

If yes, explain _____

Based on the above ROOT CAUSE ANALYSIS, what was the root cause of this incident?_____

Does this incident require additional investigation? Y☐ N☐ If yes, please explain. (*Attach additional sheets if needed*)

_____

RECOMMENDATIONS TO PREVENT RECURRENCE (What can be done to prevent another similar injury?)

_____

Supervisor Signature: _____ Date ___/___/____

Location Manager Name: _____ Signature: _____ Pass #_____

New York City Transit Authority **WAIVER AND ELECTION**
TWU, ATU EMPLOYEES
REQUEST FOR PAYMENT WHILE ABSENT DUE TO SERVICE CONNECTED DISABILITY

I, _____, request eight hours pay for each work day I am absent due to a service connected injury. Such payment shall begin with the first work day of absence and will be charged against my accrued sick leave ☐ and/or vacation time ☐ (*check one or both*) and will continue if eligible for maximum 20 days until I return to work, whichever comes first. I understand that, in making this request, I am waiving any rights which I might otherwise have to use such accrued time for other reasons. I understand that I must provide medical documentation from my treatment provider pursuant to the Workers' Compensation Law and, if I do not provide such information and do not certify my absence through providing a sick leave application/doctor's certification, benefits paid to me through this waiver and election will be recouped.

Date_____ Signed_____

Pass _____ Title _____

Department_____

Date of Accident _____

Date of Initial Absence _____

To be completed by Department/Division:

The Workers Compensation Division has indicated that this case is

*****Controverted *****Non-Controverted per _____(name) on _____(date).

Sick Leave Balance _____ Annual Leave Balance _____

Payroll payment commenced _____

Department will submit a copy of this form to Timekeeping, Payroll and the Workers' Compensation Division *immediately* upon completion of this section. If the ***** information is not available complete the remaining portion and transmit as indicated.

Print Name: _____ **Title:**_____

Authorized Signature_____**Date**_____**Phone #**_____

Upon return to duty or exhaustion of leave credits, department shall complete and submit a copy of this form to the Workers Compensation Division:

Date returned to duty _____ Date leave credits exhausted _____

Leave Used: _____ Sick Leave Days _____ Vacation Days (insert number of days)

Amount paid: $_____

Print Name: _____ **Title:**_____

Authorized Signature_____**Date**_____**Phone #**_____

Workers Compensation Division shall complete and send to employee's department and Payroll:

Workers Compensation paid at $_____/week for _____ to _____.

Workers Compensation paid at $_____/week for _____ to _____.

Differential pay should be granted for _____ to _____.

Authorized Signature_____**Date**_____**Phone #**_____

Department to complete and file:

Based on above award(s), employee is entitled to be credited with

_____sick leave and/or _____ vacation days.

Print Name: _____ **Title:**_____

Authorized Signature_____**Date**_____**Phone #**_____

NEW YORK CITY TRANSIT
ON THE JOB INJURY MANAGEMENT FOLLOW-UP FORM

Employee Name:_____
Title:_____
Pass Number:_____
Department/Division:_____
Division RC:_____
Work Location:_____
Telephone:_____
Fax Number:_____

Manager Name:_____
Title:_____
Pass Number:_____
Department/Division:_____

Date of injury:_____
Description of injury_____

Action Taken:

☐ Emergency Room
Hospital:_____
Address:_____
Telephone:_____
Physician:_____

☐ Personal Physician
Name:_____
Address:_____
Telephone:_____

☐ Medical Assessment Center (MAC), or
☐ Independent Medical Examiner (IME)
Location:_____
Physician:_____
Telephone:_____

Other, explain:_____

Employee condition:_____

☐ Non- work related condition identified, explain:_____

Can employee work the following day? ☐ Yes ☐ No
If No, when can employee return to work? _____
If return date is unknown, when is employee's next evaluation? _____

☐ Contact day of employee: _____
☐ Full duty: perform routine tasks
☐ Restricted, explain: _____

☐ Restricted work available
☐ Restricted work unavailable
☐ Return to full work Date:_____
☐ Employee failed to report to full work Date:_____
☐ Employee failed to keep MAC/IME visit Date:_____

Manager's Signature _____

Date _____

MTA New York City Transit

rev. 08/03/10

WORKERS' COMPENSATION MEDICAL FORM
NYCT, MABSTOA, MTA BUS, MTA (HEADQUARTERS AND POLICE) AND SIRTOA (updated 5/17/19)

TO BE FILLED OUT BY CLAIMANT AND HIS/HER PROVIDER
THIS FORM IS NOT A SUBSTITUTE FOR A C-4 OR ANY OTHER WCB AUTHORIZED MEDICAL FORM

Section A: To be completed by employee. (COMPLETE THIS SECTION and PLEASE PRINT LEGIBLY)
THIS FORM MUST BE RETURNED TO EMPLOYEE'S DEPARTMENT AFTER VISIT TO TREATING PROVIDER/PHYSICIAN.
MTA POLICE FAX OR EMAIL FORM TO MEDICAL CONTROL UNIT, FAX 212-878-4697

Employee Name_____ Date of Accident_____
Pass No._____ Job Title on Date of Accident_____ Department_____
Current Job Title _____ Current Supervisor Name _____
Home Address _____
_____
Personal E-mail Address_____ Phone No._____
Employee's Signature_____ Date of Exam_____

Section B: To be completed by treating physician/provider. (COMPLETE THIS SECTION and PLEASE PRINT LEGIBLY)

Next Exam Date _____

- Current disability directly related to accident? Yes☐ No☐ Unknown☐
- Work Status: Full Work☐ No Work☐ Restricted Work☐
  ONLY IF RESTRICTED, check **one** Degree of Disability: Mild☐ Moderate☐ Marked☐
- If Work Restrictions: Temporary☐ Permanent☐

Employee's Restrictions (please check all that apply):
Work Indoors☐ Work Outdoors☐ Work in Booth☐ Work at Heights☐ Operate Motor Vehicle☐
Operate Mechanical Equipment☐ Perform Repetitive Movements☐ Travel via Public Transportation☐
Carry/Operate Firearms (MTA Police Only) ☐ Twisting☐ Climbing☐ Bending☐ Kneeling☐ Sitting☐
Walking☐ Weight Limit Greater than 10lbs: Lifting☐ Pushing☐ Pulling☐

- How long will these limitations apply? 1-2 days☐ 3-7 days☐ 8-14 days☐ 15+days☐ N/A☐
- How Many Drugs Taken? _____ Impacts Functional Abilities? Yes☐ No☐
- Name of Drug(s):_____
  Please Note: Employees found Full Work must provide medical on continuing need for drugs.
- Physician Diagnosis/Objective Findings/Request for Treatment/Notes _____
  _____

Provider Name/Specialty _____ Date of Exam _____
Provider Address_____ Phone No._____
Provider Fax No. _____ Provider E-mail Address_____
Provider Signature_____ WCB Authorization No. _____

Section C: To be completed by treating physician/provider. (COMPLETE THIS SECTION and PLEASE PRINT LEGIBLY)

SLU ONLY? Yes☐ No☐ **If SLU Only: SLU Percentage _____%**

Agency Use Only (PLEASE PRINT LEGIBLY)

Department **Employee's Supervisor: Complete and email to assigned examiner and manager.**
Work Available? Yes☐ No☐ Return to Work Date _____ Phone No. _____
Supervisor Name_____ Supervisor Signature _____ Date_____

MAC Drug Testing (If Required) Drug screen completed: Yes ☐ No ☐ Time Departed _____
Authorized Personnel _____ Signature _____ Date _____

WORKERS' COMPENSATION INJURY/ILLNESS ON DUTY
INSTRUCTION SHEET

To avoid **DELAY** or **DENIAL** of **COMPENSATION, DIFFERENTIAL or ASSAULT** pay, the following procedures MUST be followed when claiming a job related injury.

1. **COMPLETE THE INJURYON DUTY REPORT WITH DIFFERENTIAL APPLICATION IMMEDIATELY** Late filing may result in a DELAY in COMPENSATION PAYMENTS AND DENIAL of DIFFERENTIAL PAY.

2. **READ THOROUGHLY STATEMENT OF RIGHTS** published by the New York State Workers' Compensation Board.

3. **REQUEST FOR PAYMENT WHILE ABSENT DUE TO CLAIMED SERVICE-CONNECTED DISABILITY** If provided for in the relevant collective bargaining agreement, NYC Transit Authority employees, who are not receiving workers' compensation payments, may request to use his/her sick leave and/or vacation time beginning with the 1st day of absence by submitting the appropriate form. You should contact your supervisor and/or union representative if you have any questions about this process.

4. **YOUR OWN PRIVATE PHYSICIAN'S CARE:** Your physician must file a **C-4 OR C-48** form with the Authority's Workers' Compensation Division and the Workers' Compensation Board as soon as possible. Absent receipt of the C-4 or requisite, acceptable medical lines (these must include diagnosis, medical findings, not solely conclusions, and a work status – see form supplied by Supervisor) from your treating physician by the Workers' Compensation Division, your workers' compensation* and differential benefits will not commence. Failure to submit medical documentation may result in your being considered absent without leave. Additional medical lines may be requested by the Workers' Compensation Division. All physician medical invoices are to be mailed to the Workers' Compensation address listed below.

5. **INDEPENDENT MEDICAL EXAMINATION (IME)**

   - **REPORT TO AUTHORITY IME PHYSICIAN AS DIRECTED BY** the mail notice you receive (by express and/or regular mail and possibly by hand). The notice will be received at least seven business days (excluding Saturday and Sunday) before the scheduled examination.

   - **IF YOU RETURN TO WORK PRIOR TO YOUR IME APPOINTMENT** you must report to the Safety Unit at 130 Livingston Street, 6th floor on your next scheduled work day, Sunday through Saturday, between 0800 -1600 hours, **IN FULL UNIFORM.** You must bring with you acceptable medical lines and a copy of your completed On the Job Injury form. The Safety Unit will inform you, based on the determination made by the Workers' Compensation Division if your must keep your scheduled IME appointment.

   - **A FAILURE TO REPORT TO THE MEDICAL IME EVALUATION** may result in a denial of workers' compensation* or differential benefits. If you have returned to work prior to the scheduled IME examination, you should check to determine whether the examination is still required.

   - **IF UNABLE TO TRAVEL TO THE IME EVALUATION:** You must give your department and the Workers' Compensation Division at least two business days advance notice if you cannot go to the consultant physician on the scheduled date. If unable to attend the Medical IME Evaluation, you must call/fax the Medical Consultant Unit listed below for notification. You will be required to prove your inability to attend. Ask your physician to provide his/her written opinion of your inability to travel. Absent such proof, your differential benefits may be jeopardized and you may be considered AWOL. If requested by the employee, the Authority may, based upon the circumstances, arrange for a home or hospital visit for evaluation of your medical condition.

- **OBTAIN WORK STATUS FROM MEDICAL IME AND RETURN TO YOUR DEPARTMENT:** The IME Physician will give you a Medical IME Evaluation Form which will indicate your work status - Full Work, Restricted Duty or No Work. Unless you receive directions otherwise from your department, after you receive the Medical IME Evaluation Form return to ***Employee Availability, 130 Livingston Street, 6th floor, Monday through Friday,*** the Form. Your department will determine whether work is available within the restrictions indicated by the Independent Medical Examination.

**** Subject to review by the Workers' Compensation Board.***

- **IF YOU DISAGREE WITH THE WORK STATUS DETERMINATION:** Contact your Department for instructions. If your physician's opinion regarding your work status differs from the Authority's IME physician, medical evidence (with objective findings) should be submitted in writing for review to the Injury Reporting Unit of your department and the Workers' Compensation Division at the address stated below. If you dispute a full or restricted work status give by the IME and do not return to work, you may be denied workers compensation benefits and or differential benefits. If you are uncertain about how to proceed you are to contact your supervisor and/or Union Representative for clarification.

- **A COPY OF THE IME/MEDICAL REPORT** will be forwarded to you.

- **RE-EXAMINATIONS:** You must continue to report to the Authority's IME physician as noticed in subsequent mailed notification, as well as by hand delivery at the current medical examination. You are required to bring current reports from your doctor concerning your medical status.

KEEP IN CONTACT WITH YOUR DEPARTMENT

**	Workers Compensation Division	MABSTOA	(718) 694-3820
		TA Letter A - K	(718) 694-4860
		TA Letter L - Z	(718) 694-4843
		SIRTOA	(718) 694-3820

Address: 130 Livingston St., 10th Floor
Brooklyn, New York 11201

For questions related to medical consultant evaluations and/or medical documentation please contact the Medical Consultant Unit:

Phone #s:	(718) 694-3811
	694-1870
	694-3278
Fax #s:	(718) 694-3100
	694-1610

**** Employee should select telephone number that corresponds to initial of last name.**

STATE OF NEW YORK
David A. Paterson, Governor

WORKERS' COMPENSATION BOARD
Robert E. Beloten, Chair

STATEMENT OF RIGHTS

TO ALL WORKERS WHO ARE INJURED WHILE WORKING OR WHO SUFFER FROM AN OCCUPATIONAL DISEASE

YOU MAY BE ENTITLED TO WORKERS' COMPENSATION BENEFITS

1. You should file a claim for benefits within two years of the date you are injured, unless your injury is very minor, requiring no medical treatment and causing no lost time from work. If you do not file within two years your right to benefits may be lost. Obtain and file a claim form (Form C-3, or VF-3 for volunteer firefighters, or VAW-3 for volunteer ambulance workers) with the nearest Workers' Compensation Board office (see addresses below).
2. You may be entitled to lost time benefits if your work-related 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. You may be entitled to rehabilitation services if you need help returning to work. (In volunteer firefighters' and volunteer ambulance workers' cases, compensation for lost time or loss of earning capacity may be payable from date of injury.)
3. You are entitled to obtain any necessary medical treatment related to your injury and you should do so immediately.
4. For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Board authorized and who is accepting workers' compensation patients. If, however, your employer is involved in a certified preferred provider organization (PPO) arrangement, you must obtain initial treatment for any workers' compensation injury or illness from the preferred provider organization. Employers participating in this statutory program are required to provide their employees with written notification describing their employees' rights and obligations under the program.
5. You should inform your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and your employer's insurance company, which is indicated at the bottom of this form.
6. You should not pay any medical providers directly for treatment of your work-related injury or illness. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
7. The employer is liable for the replacement or repair of an employee's prosthesis (e.g., artificial members, false teeth, eyeglasses), which has been lost or damaged in the course of employment, whether or not there was bodily injury to the employee. You are also entitled to be reimbursed for drugs, crutches or any apparatus properly prescribed by your doctor, and transportation and other necessary expenses going to and from your doctor's office or hospital. (You should get receipts for all such expenses.)
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire an attorney or licensed representative, you should not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. Lost time and medical benefits are payable directly without a formal direction from the Board, unless your claim is disputed. If your claim is disputed on the grounds that your injury is not work-related or did not arise in the line of volunteer firefighter or ambulance worker duties, then you may qualify for disability benefits for non-work injuries. For more information on entitlement to disability benefits, contact the Workers' Compensation Board office nearest you.
10. You should go back to work as soon as you are able; compensation is never as high as your wage. If you need help returning to work, or with family or financial problems because of your injury, you should contact the nearest Board office and ask for a rehabilitation counselor or social worker.
11. Your employer may not ask you to waive your right to compensation nor may your employer deduct any money from your pay to contribute to the payment of workers' compensation insurance premiums. Further, you cannot be discharged or discriminated against because you filed a claim for workers' compensation benefits.

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A JOB-RELATED INJURY OR DISEASE, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights under the Workers' Compensation Law. It is provided, as required by Section 110 of the Workers' Compensation Law, by your employer's insurance carrier:

MTA-NYC Transit Workers Compensation Dept.
130 Livingston Street, 10th Floor
Brooklyn, New York 11201 718-694-4851



ROBERT E. BELOTEN
CHAIR

DOWNSTATE CENTRALIZEDMAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552

100 Broadway Menands	State Office Building 44 Hawley Street	369 Franklin Street	130 Main Street W.	935 James St.
ALBANY 12241	BINGHAMTON 13901	BUFFALO 14202	ROCHESTER 14614	SYRACUSE 13203
(866) 750-5157	(866) 802-3604	(866) 211-0645	(866) 211-0644	(866) 802-3730

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

C-430S (8-09)

ESTE RESUMEN ESTÁ ESCRITO EN ESPAÑOL AL DORSO

Fax: 877-533-0337
www.wcb.state.ny.us

ESTADO DE NUEVA YORK
David A. Paterson, Gobernador

DECLARACION DE DERECHOS

JUNTA DE COMPENSACION OBRERA
Robert E. Beloten, Presidente

A TODO EMPLEADO LESIONADO EN EL TRABAJO O QUE SUFRA DE ENFERMEDAD OCUPACIONAL: USTED PUEDE TENER DERECHO A BENEFICIOS DE COMPENSACION OBRERA

1. Usted deberá presentar una reclamación de beneficios dentro del término de dos años del dia en que fue lesionado, a menos que la lesión sea tan pequeña que no requiera tratamiento médico y que no cause interrupción en su jornada de trabajo. Si no radica dentro del término de dos años, puede perder sus derechos a beneficios. Consiga y radique una forma de reclamación (Forma C-3, o VF-3 para bomberos voluntarios, o VAW-3 para empleados voluntarios de ambulancias) en la oficina más cercana de la Junta de Compensación Obrera (direcciones más abajo).
2. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo. (Bomberos voluntarios y Trabajadores de Ambulancia Voluntarios pueden ser compensados desde el mismo dia de su lesión.)
3. Usted tiene derecho a recibir tratamiento médico relacionado con su lesión y debe obtenerlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en esta programa establecida por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
7. El patrono es responsable de la sustitución y reparación de aquellos implementos médicos que han sido perdidos o se han deteriorado como consecuencia del empleo, sin que importe el que el empleado haya onosufrido lesión (Ej. miembros artificiales, dentadura postiza, espejuelos). Usted tambien tiene derecho a ser reembolsado por medicinas, muletas, o cualquier otro implemento debidamente recetado por su médico y por transportación u otro gasto necesario para ir al médico óalhospital. (Obtenga recibos para justificar gastos.)
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. La compensación se paga inmediatamente, sin esperar por la adjudicación del caso, excepto cuando la reclamación es cuestionada. Si la reclamación es cuestionada en base a que la incapacidad no fue causada por un accidente relacionado con su trabajo ó por una enfermedad ocupacional ó por una lesión en el cumplimiento de su deber como bombero voluntario ó como miembro voluntario del cuerpo de ambulancia, usted puede tener derecho a recibir beneficios por incapacidad (para lesiones fuera del trabajo). Si su reclamación es cuestionada y no está recibiendo beneficios por incapacidad, comuniquese con cualquier oficina de la Junta.
10. Regrese a su trabajo tan pronto pueda. La compensación nunca es tan alta como su sueldo. Si necesita ayuda para regresar al trabajo ó para resolver problemas financieros ó personales por causa de la lesión sufrida, comunicate con la oficina mas cercana de la Junta y solicita hablar con un trabajador social o con un consejero de rehabilitación.
11. Su patrono no puede solicitar que usted le releve de su derecho a compensación, ni puede descontar cantidad alguna de su paga para contribuir al pago de las primas del seguro. Usted no podrá ser despedido ni penalizado por radicar una reclamación en la Junta.

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLAMACIÓN O NECESITA AYUDA PARA LLENARLO Ó TIENE DUDAS SOBRE CUALQUIER SITUACIÓN RELACIONADA CON UNA LESIÓN O ENFERMEDAD COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA.

Este resumen es una compilación de los puntos más importantes de sus derechos bajo la ley de compensación obrera. La sección 110 de la ley requiere de su patrono ofrecerle esta información.

MTA-NYC Transit Workers Compensation Dept.
130 Livingston Street, 10th floor
Brooklyn, New York 11201 718-694-4851



ROBERT E. BELOTEN
PRESIDENTE

DOWNSTATE CENTRALIZEDMAILING	100 Broadway	State Office Building			
(for New York City, Hempstead, Hauppauge & Peekskill Districts)	Menands	44 Hawley Street	369 Franklin Street	130 Main Street W.	935 James St.
PO Box 5205 Binghamton, NY 13902-5205	ALBANY 12241	BINGHAMTON 13901	BUFFALO 14202	ROCHESTER 14614	SYRACUSE 13203
NYC (800)877-1373/ Hemp. (866)805-3630/ Haup. (866)681-5354/ Peek. (866)746-0552	(866) 750-5157	(866) 802-3604	(866) 211-0645	(866) 211-0644	(866) 802-3730

C-430S (8-09)

THIS NOTICE IS WRITTEN IN ENGLISH ON THE REVERSE SIDE.

Fax: 877-533-0337
www.wcb.state.ny.us

Doctor's Initial Report

C-4

State of New York - Workers' Compensation Board

Use this form to report the *first* time you treated the patient. (To report continued treatment, use Form C-4.2. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.state.ny.us.

A. Patient's Information

1. Name: _____ (Last / First / MI) 2. Social Security #: ___ - ___ - ____

3. Home phone #: (____)_____ 4. WCB Case # (if known): _____ 5. Carrier Case #: _____

6. Mailing address: _____ (Number and Street) _____ (City) _____ (State) _____ (Zip Code)

7. Date of injury/onset of illness: ____/____/____ 8. Date of Birth: ____/____/____ 9. Gender: ☐ Male ☐ Female

10. On the date of injury/illness what was the patient's job title or description: _____

11. On the date of injury/illness what were the patient's usual work activities: _____

_____

12. Patient's Account #: _____

B. Employer Information

1. Employer when injury occurred: _____ (Company/Agency Name) 2. Phone #: (____)_____

3. Employer Address: _____ (Number and Street) _____ (City) _____ (State) _____ (Zip Code)

C. Doctor's Information

1. Your name: _____ (Last / First / MI) 2. WCB Authorization #: _____

3. WCB Rating Code: _____ 4. Federal Tax ID #: _____ The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: _____ (Number and Street) _____ (City) _____ (State) _____ (Zip Code)

6. Billing group or practice name: _____

7. Billing address: _____ (Number and Street) _____ (City) _____ (State) _____ (Zip Code)

8. Office phone #: (____)_____ 9. Billing phone #: (____)_____ 10. Treating Provider's NPI #: _____

11. You are a (*check one*): ☐ Physician ☐ Podiatrist ☐ Chiropractor

D. Billing Information

1. Employer's insurance carrier: _____ 2. Carrier Code #: **W** _____

3. Insurance carrier's address: _____ (Number and Street) _____ (City) _____ (State) _____ (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD9 Code:	ICD9 Descriptor:
(1)		
(2)		
(3)		
(4)		

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column on page 2 by line.

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

Patient's Name: _____ Date of injury/onset of illness: _____/_____/_____
Last First MI

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$	$	$

E. History

1. Based on the patient's history, where and how did the injury/illness happen: _____

2. How did you learn about the injury/illness (*check one*): ☐ Patient ☐ Medical Records ☐ Other(*specify*): _____

3. Did another health provider treat this injury/illness including hospitalizaton and/or surgery? ☐ Yes ☐ No If yes, give details:

4. Have you previously treated this patient for a similar work-related injury/illness? ☐ Yes ☐ No If yes, when: _____

F. Exam Information

1. Date(s) of Examination: _____

2. Patient's subjective complaints: *Check all that apply and identify specific affected body part(s).*

☐ Numbness/Tingling _____ ☐ Swelling _____
☐ Pain _____ ☐ Weakness _____
☐ Stiffness _____ ☐ Other (*specify*) _____

3. Type/nature of injury: *Check all that apply and identify specific affected body part(s).*

☐ Abrasion _____ ☐ Infectious Disease _____
☐ Amputation _____ ☐ Inhalation Exposure _____
☐ Avulsion _____ ☐ Laceration _____
☐ Bite _____ ☐ Needle Stick _____
☐ Burn _____ ☐ Poisoning/Toxic Effects _____
☐ Contusion/Hematoma _____ ☐ Psychological _____
☐ Crush Injury _____ ☐ Puncture Wound _____
☐ Dermatitis _____ ☐ Repetitive Strain Injury _____
☐ Dislocation _____ ☐ Spinal Cord Injury _____
☐ Fracture _____ ☐ Sprain/Strain _____
☐ Hearing Loss _____ ☐ Torn Ligament,Tendon or Muscle _____
☐ Hernia _____ ☐ Vision Loss _____
☐ Other (*specify*) _____

Patient's Name: _____ Date of injury/onset of illness: _____/_____/_____
Last First MI

4. Physical examination: *Check all relevant objective findings and identify specific affected body part(s).*

- ☐ None at present
- ☐ Bruising _____
- ☐ Burns _____
- ☐ Crepitation _____
- ☐ Deformity _____
- ☐ Edema _____
- ☐ Hematoma/Lump/Swelling _____
- ☐ Joint Effusion _____
- ☐ Laceration/Sutures _____
- ☐ Pain/Tenderness _____
- ☐ Scar _____
- ☐ Other findings: _____

- ☐ Neuromuscular Findings:
  - ☐ Abnormal/Restricted ROM
    - ☐ Active ROM _____
    - ☐ Passive ROM _____
  - ☐ Gait _____
  - ☐ Palpable Muscle Spasm _____
  - ☐ Reflexes _____
  - ☐ Sensation _____
  - ☐ Strength (Weakness) _____
  - ☐ Wasting/Muscle Atrophy _____

5. Describe any diagnostic test(s) rendered at this visit: _____

6. Describe any treatment(s) rendered at this visit: _____

7. Describe prognosis for recovery: _____

8. Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? ☐ Yes ☐ No
If yes, list and describe: _____

G. Doctor's Opinion

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☐ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☐ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☐ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? _____%
5. Describe findings and relevant diagnostic test results: _____

H. Plan of Care

1. What is your proposed treatment? _____

2. Medication(s):(a) list medications prescribed: _____
(b) list over-the-counter medications advised: _____

Medication restrictions: ☐ None ☐ May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below:

Patient's Name: _____ Date of injury/onset of illness: ____/____/____
Last First MI

3. Does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:

- ☐ CT Scan
- ☐ EMG/NCS
- ☐ MRI (Specify): _____
- ☐ Labs (Specify): _____
- ☐ X-rays (Specify): _____
- ☐ Other (Specify): _____

Referrals:

- ☐ Chiropractor
- ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in _____
- ☐ Other (Specify): _____

4. Assistive devices prescribed for this patient: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair
☐ Other (specify): _____

Important: *Form C-4 AUTH should be utilized to request any special medical service over $1000.*

5. When is the patient's next follow-up appointment?
☐ Within a week ☐ 1-2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ 7-8 weeks ☐ _____months ☐ Return as needed

I. Work Status

1. Has the patient missed work because of the injury/illness? ☐ Yes ☐ No If yes, date patient first missed work: ____/____/____
Is the patient currently working? ☐ Yes ☐ No If yes, did the patient return to: ☐ usual work activities ☐ limited work activities

2. Can the patient return to work? (*check only one*):

a. ☐ The patient cannot return to work because (explain): _____

b. ☐ The patient can return to work without limitations on _____/_____/_____

c. ☐ The patient can return to work with the following limitations (check all that apply) on _____/_____/_____

- ☐ Bending/twisting
- ☐ Climbing stairs/ladders
- ☐ Environmental conditions
- ☐ Kneeling
- ☐ Lifting
- ☐ Operating heavy equipment
- ☐ Operation of motor vehicles
- ☐ Personal protective equipment
- ☐ Sitting
- ☐ Standing
- ☐ Use of public transportation
- ☐ Use of upper extremities
- ☐ Other (explain): _____

Describe/quantify the limitations: _____

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's return to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

_____ _____ _____ ____/____/____
Name Signature Specialty Date

MEDICAL REPORTING

IMPORTANT-TO THE ATTENDING DOCTOR

1. This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases as follows:

   48 HOUR INITIAL REPORT - Prepare and submit this form, complete in all details, within 48 hours after you first render treatment.

   If you continue to treat, use form C-4.2 for future reporting. DO NOT use this form for future reporting.

   All reports are to be filed with the Workers' Compensation Board, the workers' compensation insurance carrier, self-insured employer, and if the patient is represented by an attorney or licensed representative, with such representative. If the claimant is not represented, a copy must be sent to the claimant.

   Ophthalmologists use form C-5, Occupational/Physical Therapists use form OT/PT-4 and Psychologists use form PS-4 for filing reports.

2. Please ask your patient for his/her WCB Case Number and the Insurance Carrier's Case Number, if they are known to him/her, and show these numbers on your reports. In addition, ask your patient if he/she has retained a representative. If so, ask for the name and address of the representative. You are required to send copies of all reports to the patient's representative, if any.

3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. If the patient is hospitalized, it may be signed by a licensed doctor to whom the treatment of the case has been assigned as a member of the attending staff of the hospital.

4. **AUTHORIZATION FOR SPECIAL SERVICES** - Form C-4 AUTH should be utilized to request any special medical service over $1000.

   AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY

5. **LIMITATION OF PODIATRY TREATMENT** - Podiatry treatment is limited as defined in Section 7001 of the Education Law and Section 13-k(2) of the Workers' Compensation Law.

6. **LIMITATION OF CHIROPRACTIC TREATMENT** - Chiropractic treatment is limited as defined in Section 6551 of the Education Law and the Chair's Rules Relative to Chiropractic Practice Under Section 13-I of the Workers' Compensation Law.

   A CHIROPRACTOR OR PODIATRIST FILING THIS REPORT CERTIFIES THAT THE INJURY DESCRIBED CONSISTS SOLELY OF A CONDITION(S) WHICH MAY LAWFULLY BE TREATED AS DEFINED IN THE EDUCATION LAW AND, WHERE IT DOES NOT, HAS ADVISED THE INJURED PERSON TO CONSULT A PHYSICIAN OF HIS/HER CHOICE.

7. **HIPAA NOTICE** - In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

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.

BILLING INFORMATION

Complete all billing information contained on this form. Use continuation Form C-4.1, if necessary. The workers' compensation carrier has 45 days to pay your bill or to file an objection to it. Contact the workers' compensation carrier if you receive neither payment nor an objection within this time period. After contacting the carrier, you may, if necessary, contact the Board's Disputed Bill Unit, at the Albany address indicated below, for information/assistance.

IMPORTANT TO THE PATIENT

YOUR DOCTORS' BILLS (AND BILLS FOR HOSPITALS AND OTHER SERVICES OF A MEDICAL NATURE) WILL BE PAID BY YOUR EMPLOYER, THE LIABLE POLITICAL SUBDIVISION OR ITS INSURANCE COMPANY OR THE UNAFFILIATED VOLUNTEER AMBULANCE SERVICE IF YOUR CLAIM IS ALLOWED. DO NOT PAY THESE BILLS YOURSELF, UNLESS YOUR CASE IS DISALLOWED OR CLOSED FOR FAILURE TO PROSECUTE.

IF YOU HAVE ANY QUESTIONS CONCERNING THIS NOTICE OR YOUR CASE, OR WITH RESPECT TO YOUR RIGHTS UNDER THE WORKERS' COMPENSATION LAW, OR THE VOLUNTEER FIREFIGHTERS' OR VOLUNTEER AMBULANCE WORKERS' LAWS, YOU SHOULD CONSULT THE NEAREST OFFICE OF THE BOARD FOR ADVICE. **ALWAYS USE THE CASE NUMBERS SHOWN ON THE OTHER SIDE OFTHIS NOTICE,** OR ON OTHER PAPERS RECEIVED BY YOU, IF YOU FIND IT NECESSARY TO COMMUNICATE WITH THE BOARD OR THE CARRIER. ALSO, MENTION YOUR SOCIAL SECURITY NUMBER IF YOU WRITE OR CALL THE BOARD.

IMPORTANTE PARA EL PACIENTE

LAS FACTURAS POR SERVICIOS MEDICOS INCLUYENDO HOSPITALES Y TODO SERVICIO DE NATURALEZA MEDICA SERA PAGADO POR EL PATRONO O POR LA ENTIDAD RESPONSABLE O SU COMPANIA DE SEGUROS SEGUN SEA EL CASO; SI SU RECLAMACION ES APROBADA. NO PAGUE ESTAS FACTURAS A MENOS QUE SU CASO SEA DESESTIMADO EN SU FONDO O ARCHIVADO POR NO REALIZAR LOS TRAMITES CORRESPONDIENTES.

SI USTED TIENE ALGUNA PREGUNTA, EN RELACION A ESTA NOTIFICACION O A SU CASO O EN RELACION A SUS DERECHOS BAJO LA LEY DE COMPENSACION OBRERA O LA LEY DE BOMBEROS VOLUNTARIOS O LA LEY DE SERVICIOS DE AMBULANCIAS VOLUNTARIOS DEBE COMUNICARSE CON LA OFICINA MAS CERCANA DE LA JUNTA PARA ORIENTACION. SIEMPRE USE EL NUMERO DEL CASO QUE APARECE EN LA PARTE DEL FRENTE DE ESTA NOTIFICACION, O EN OTROS DOCUMENTOS RECIBIDOS POR USTED. SI LE ES NECESARIO COMUNICARSE CON LA JUNTA O CON EL "CARRIER."

TAMBIEN MENCIONE EN SU COMUNICACION ORAL O ESCRITA SU NUMERO DE SEGURO SOCIAL.

WORKERS' COMPENSATION BOARD DISTRICT OFFICES

Reports should be filed by sending directly to the appropriate WCB district office (DO) at the address below with a copy sent to the insurance carrier:

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 NY 13901 866-802-3604 (for accidents in the following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)

Buffalo DO - 369 Franklin Street, Buffalo NY 14202 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)

Statewide Fax Line: 877-533-0337

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): _____

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

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)

C-3.3

State of New York - Workers' Compensation Board

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)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

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

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

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 - Statler Towers, 107 Delaware Avenue, Buffalo NY 14202 (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)