STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

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

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

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

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

W.B.C. CASE NO. (IF KNOWN)	CARRIER CASE NO.	CARRIER CODE NO.	WC POLICY NO.	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 mailing address)	(e) NATURE OF BUSINESS (Principal Products, Services, etc.)	(f) NYS U.I. EMPLOYER REG. NO.

2. (a) INSURANCE CARRIER	(b) CARRIER'S ADDRESS
NEW YORK CITY LAW DEPT., WORKER'S COMPENSATION DIV.	**350 JAY STREET, BROOKLYN, NY 11201-2908**
3. (a) INJURED EMPLOYEE (First, M.I., Last)	(b) ADDRESS (Include No. & Street, City, State, Zip & Apt. No.)

ACCIDENT

4. (a) ADDRESS WHERE ACCIDENT OCCURRED	(b) COUNTY	(c) WAS ACCIDENT ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
5. TIME OF ACCIDENT	6. DEPT. WHERE REGULARLY EMPLOYED	7. (a) DATE STOPPED WORK BECAUSE OF THIS INJURY/ILLNESS? / (b) WAS EMPLOYEE PAID IN FULL FOR DAY? ☐ YES ☐ NO

INJURED PERSON

8. SEX	9. (a) AGE	(b) DATE OF BIRTH	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.)
12. (a) PART OR FULL TIME EMPLOYED?			(b) INJURED EMPLOYEE'S WORK WEEK (Indicate days of week usually worked)

NATURE OF INJURED

13. NATURE OF INJURY AND PART(S) OF BODY AFFECTED	14. (a) DID YOU PROVIDE MEDICAL CARE?	(b) IF YES, WHEN?
15. (a) NAME AND ADDRESS OF DOCTOR	(b) NAME AND ADDRESS OF HOSPITAL	
16. (a) HAS EMPLOYEE RETURNED TO WORK?	(b) IF YES, GIVE DATE	(c) AT WHAT WEEKLY WAGE?

NOTE: FORM C-11 MUST BE FILED EACH TIME THERE IS A CHANGE IN EMPLOYMENT STATUS

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 (a) DATE OF DEATH	(b) NAME AND ADDRESS OF NEAREST RELATIVE	(c) RELATIONSHIP

PREPARATION

DATE EMPLOYER/SUPERVISOR FIRST KNEW OF INJURY	DATE OF THIS REPORT	**IF FORM IS SUBMITTED BY EMPLOYER, COMPLETE A & B BELOW** **IF FORM IS SUBMITTED BY THIRD PARTY, COMPLETE A, B, C & D BELOW**

A. EMPLOYEE PREPARING FORM OR SUPPLYING INFORMATION TO THIRD PARTY	B. TITLE	TELEPHONE NUMBER & EXTENSION
C. IF REPORT PREPARED BY THIRD PARTY, COMPANY NAME AND ADDRESS		
D. THIRD PARTY CONTACT NAME		TELEPHONE NUMBER AND ADDRESS