

**OFFICE USE ONLY**

- Information Only  
 Medical Only  
 Lost Time > 7 days

Claim # \_\_\_\_\_

# OSWEGO COUNTY SELF-INSURANCE PLAN EMPLOYER'S FIRST REPORT OF WORK-RELATED INJURY/ILLNESS

**C-2F**

A work-related injury or illness must be reported within 10 days (Section 110 of the Workers' Compensation Law) of the injury/illness or be subject to a penalty. **EMPLOYER/SUPERVISOR MUST COMPLETE (NOT INJURED EMPLOYEE)** and file a report for **ANY** on-the-job injury/illness regardless if it resulted in medical treatment or lost time. All questions must be answered completely. If you have questions regarding the completion or filing of this form, please contact the Oswego County Self-Insurance Plan Office at (315) 349-8285. **To submit form, please mail, fax or send electronically:**

**Oswego County Self-Insurance Plan**

46 East Bridge Street  
 Oswego, NY 13126  
 Fax: (315) 349-8254  
 E-mail: [mturner@oswegocounty.com](mailto:mturner@oswegocounty.com)

Employee Name \_\_\_\_\_

Date of Injury \_\_\_\_\_ Time of Injury \_\_\_\_\_ Time Work/Shift Started \_\_\_\_\_

**INSURER / CLAIM ADMINISTRATOR INFORMATION**

Insurer Name Oswego County Self-Insurance Plan Insurer ID W859003  
 Name Triad Group, LLC  
 Info/Attn N/A  
 Address 185 Jordan Road  
 City Troy State NY  
 Zip Code 12180 Country USA  
 Claim Admin ID T100068

**EMPLOYEE INFORMATION**

First Name \_\_\_\_\_ Middle Name/Initial \_\_\_\_\_  
 Last Name \_\_\_\_\_ Suffix \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Zip Code \_\_\_\_\_ Country USA  
 Phone Number \_\_\_\_\_ Date of Hire \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Gender  Male  Female  
 Employee SSN \_\_\_\_\_ Email Address \_\_\_\_\_  
 Job Title (if applicable) \_\_\_\_\_

**CLAIM INFORMATION**

Date Employer Had Knowledge of the Injury \_\_\_\_\_  
 Date Employer Had Knowledge of Date of Disability \_\_\_\_\_  
 Employment Status  Full Time  Part-Time  Seasonal  Volunteer  Other  
 Estimated Weekly Wage \_\_\_\_\_ Number of Days Worked Per Week \_\_\_\_\_

**INJURY INFORMATION**

Full Wages Paid for Date of Injury Yes No      Employer Paid Salary in Lieu of Compensation Yes No

Initial Treatment    No Medical Treatment    Minor On-Site Treatment By Employer    Minor Clinic/Hospital Treatment  
Emergency Evaluation    Hospitalization Greater Than 24 hours    Future Major Medical/Lost Time Anticipated

Date of employee's first medical treatment? \_\_\_\_\_

Medical Provider/Facility Name (i.e. Dr. John Smith or Oswego Hospital ER) \_\_\_\_\_

Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc) \_\_\_\_\_

Part of Body (i.e. left arm, right foot, head, multiple, etc) \_\_\_\_\_

Cause of Injury (i.e. Motor Vehicle, Machine, Strain, or Injury by lifting, etc) \_\_\_\_\_

Accident/Injury Description (see instructions) \_\_\_\_\_

**HOW SERIOUS WAS THE INJURY? (CHECK ONE)**

- Did not require treatment
- Did not require treatment more than First Aid.
- Required treatment more than First Aid, but did not result in lost time.
- Resulted in lost time. **(MUST HAVE DOCTOR'S EXCUSE FOR ANY LOST TIME)**
- Restricted activity.

Death Result of Injury Yes No Unknown    Date of Death \_\_\_\_\_    Number of Dependents \_\_\_\_\_

**WORK STATUS (immediately following injury/illness)**

No Lost Time (if no lost time, please skip to next section)

Last Day Worked \_\_\_\_\_      Return to Work Type      Actual    Released

Date Disability Began \_\_\_\_\_      Physical Restrictions      Yes    No

Return to Work Date \_\_\_\_\_      Return to Work Same Employer Yes    No

**ACCIDENT LOCATION AND WITNESSES**

Location of Accident: Employers Property Lessee    Other

Organization Name (if applicable) \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_      State \_\_\_\_\_

Zip Code \_\_\_\_\_      Country \_\_\_\_\_ USA

Location Narrative \_\_\_\_\_

Witnesses

Business Phone Number

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMPLOYER INFORMATION**

Department/Municipality \_\_\_\_\_  
(e.g., Oswego County Highway, Phoenix Fire Department, Town of Minetto)

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Country USA

Physical Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Country USA

Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**INSURED INFORMATION**

Insured Name Oswego County Insured FEIN 15-6000463

Insured Type  Insured  **Self-Insured**  Uninsured Insured Location ID N/A

Policy Number ID N/A

Policy Effective Date N/A Policy Expiration Date N/A

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who **KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION** as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit **SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.**

*The above is true to the best of my knowledge and belief.*

**If prepared by the employer:**

Signature of Person Preparing Form \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Title \_\_\_\_\_ Phone Number \_\_\_\_\_