State of New York – Workers' Compensation Board
Instructions for Completing Form C-2F
"Employer's First Report of Work-Related Injury/Illness"

- **Employee Name:** Enter the name of the injured Volunteer Fire Fighter
- **WCB Case Number (JCN):** leave blank
- **Date of Injury:** Enter the date of the Injury/Illness
- **Claim Administrator Claim Number**: leave blank

Insurer / Claim Administrator Information:

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name	COUNTY OF CORTLAND FIRE DEPARTMENTS	Insurer ID	156000452
Name	FIRE DISTRICTS OF NY MUTUAL INS. CO.		
Info/Attn	KATHY MASSARO		
Address	777 CHESTNUT RIDGE ROAD, SUITE 302		
City	CHESTNUT RIDGE	State	NY
Postal Code	10977	Country	USA
Claim Admin ID	01-FDM-VF-14833100-000		

Employee Information:

- **First Name, Middle Initial, Last Name, Suffix** – the injured Volunteer Fire Fighter's full legal name.
- **Mailing Address, City, State, Postal Code, & Country** – the full address of the injured Volunteer Fire Fighter.
- **Phone Number** – the Volunteer Fire Fighter's phone number including area code.
- **Date of Hire** - the date the Volunteer Fire Fighter began work as a VFF.
- **Date of Birth** – the Volunteer Fire Fighter's date of birth.
- **Gender** – check the appropriate gender.
- **Volunteer Fire Fighter SSN** – the Volunteer Fire Fighter's Social Security Number (SSN).
- **Occupation Description** – "Volunteer Fire Fighter"

Claim Information:

- **Time of Injury** – the time when the injury/illness occurred.
- **Date Employer Had Knowledge of the Injury** – the date the Fire Department official had knowledge of the injury/illness.
- **Employment Status** – "volunteer"
- **Date Employer Had Knowledge of Date of Disability** – the date the Fire Department official was notified or became aware of Volunteer Fire Fighter's work related disability/incapacity.
- **Estimated Weekly Wage** – n/a
- **Number of Days Worked Per Week** – enter the number of regularly scheduled volunteer days per week (1-7).

Employee Injury:

- **Full Wages Paid for Date of Injury** – leave both boxes unchecked.
- **Employer Paid Salary in Lieu of Compensation** – leave both boxes unchecked.
- **Initial Treatment** – check the initial treatment type.
- **Death Result of Injury** – check *Yes*, *No* or *Unknown* to indicate if the injury/illness resulted in death.
- **Date of Death** – indicate the date of death, if applicable.
- **Number of Dependents** – the number of dependents, *if known (for death cases only).*
- **Natures of Injury -** indicate the type of injury (i.e. Laceration, Burns, Fracture, Strain, etc.).
- **Part of Body** – indicate the part of body that was injured (i.e. left arm, right foot, head, multiple, etc.).
- **Causes of Injury -** indicate what caused the injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc.).
- **Accident/Injury Description** – describe how the accident occurred and the resulting injuries.

Work Status:

- **Initial Date Last Day Worked** – the last day worked prior to lost time.
- **Return to Work Type** – check *Actual* if Volunteer Fire Fighter actually returned to work, or check *Released* if Volunteer Fire Fighter was released to work but did not do so.
- **Initial Date Disability Began** – first day of disability (lost time).
- **Physical Restrictions** – check *Yes* if the Volunteer Fire Fighter has returned to work with restrictions; check *No* if the Volunteer Fire Fighter has returned to work without restrictions.
- **Initial Return to Work Date** – if the Volunteer Fire Fighter has returned to work, indicate the initial return to work date.
- **Return to Work Same Employer** – check *Yes* if returned to same Fire Dept. otherwise check *No*.

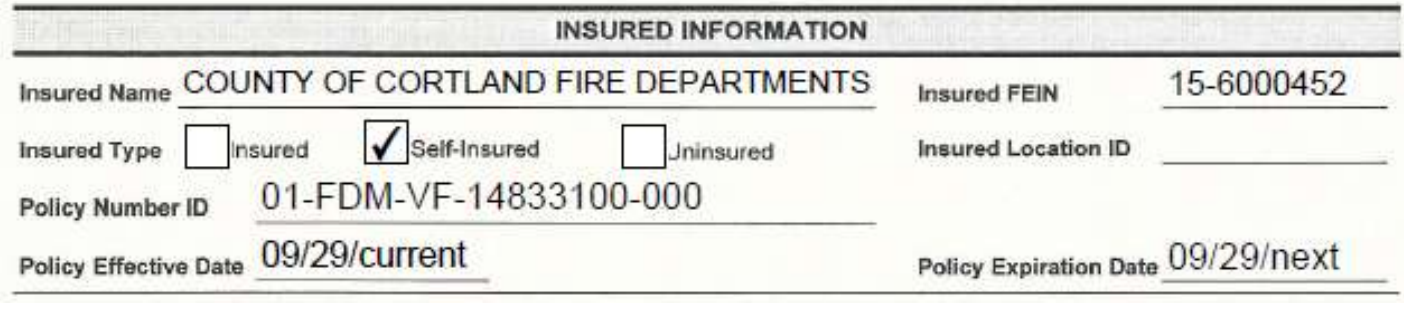
Accident Location and Witnesses:

- **Premises** – check appropriate location where injury occurred. Check *Employer*, if Volunteer Fire Fighter was injured while working for his/her own service/department. Check *Other,* if the Volunteer Fire Fighter was injured working in an official capacity for a Fire Department other than the one he/she was a member of.
- **Organization Name** – the name of the Fire Department the job was being performed for.
- **Street, City, State, Postal Code, County, & Country** – Fire Department address.
- **Location Narrative** – provide any additional description including location of fire, etc.
- **Witnesses & Business Phone Number** – indicate the names and business phone numbers of any witnesses to the injury/illness.

Employer Information:

- **Name** – **Cortland County (plus name of Fire Department)**
- **Employer FEIN –15-6000452**
- **UI Number –04-600107**
- **Manual Classification Code** – **N/A**
- **Industry Code** – the North American Industry Classification System (NAICS). **County Government**
- **Info/Attn** – indicate any additional pertinent contact information for the Fire Department.
- **Mailing Address, City, State, Postal Code, & Country** – the Fire Department's main address where you receive mail (such as a central office). Include P.O. Boxes.
- **Physical Address, City, State, Postal Code, & Country** – the physical address of the Fire Department (if different).
- **Supervisor Name** & **Supervisor Business Phone Number** – indicate the name and phone number for the Volunteer Fire Fighter's direct supervisor, including area code.

Insured Information:



NOTE:

- **Policy Effective** & **Expiration Date** – the policy effective (09/29/current) and expiration date (09/29/next); if incident occurred before 9/29 of the current year, dates should instead reflect effective date of 09/29/PREVIOUS and expiration date of 09/29/CURRENT.