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# **INJURED ON THE JOB?**

**An Employee's Guide to  
Workers' Compensation in  
New York State**



**New York State Workers' Compensation Board**

**[www.WCB.NY.Gov](http://www.WCB.NY.Gov)**

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## Privacy Statement

All documents the Workers' Compensation Board has about your case are private. Under workers' compensation law, only the parties to your claim may receive information from your case file. Beyond you and your attorney or representative, the parties who may see information include

- your employer and your employer's attorney
- your employer's workers' compensation insurance carrier and its attorney

That insurance carrier may share information with health care providers it hires to examine you. Your health care providers will have to share your health information with that insurer when they bill for their services.

Anyone who obtains a court order authorizing access to your claim information is also included. Your information may also be shared with government entities if they are processing a claim for benefits or investigating fraud.

No one may disclose your information to anyone who is not authorized to see it.

You may give written permission to anyone you choose to access your claim information, in two ways.

1. File an original Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records. This is available from [www.wcb.ny.gov/content/main/forms/Forms\\_CLAIMANT.jsp](http://www.wcb.ny.gov/content/main/forms/Forms_CLAIMANT.jsp), or by calling 1.866.750.5157.
2. File an original notarized letter or form where you authorize a particular person or entity to see your claim information.

You may submit an authorization at any time. It's always helpful to share a copy of that document with the person you authorize to see your records. Some people authorize their spouse or child to access their records when they initially file for benefits.

Prospective employers may not ask you to give them information about your workers' compensation claims before hiring you.

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The C-3 and C-3.3 forms follow the text of this document.

This pamphlet is a general, simplified presentation of  
 workers' compensation provisions and procedures.  
 It is not a substitute for the law or legal advice.

The Workers' Compensation Board does not discriminate on the  
 basis of race, color, national origin, sex, religion, age, disability or  
 sexual preference when providing services or in employment.

Workers' compensation fraud is a felony,  
 punishable by fines and up to seven years imprisonment.  
 To report fraud, call 1-888-363-6001.

## What is Workers' Compensation?

Workers' compensation is a form of insurance. Most employers must carry this insurance for workers who are injured or become ill because of their jobs. It provides for medical care, and wages you lose because your ability to work is affected. Employers pay for this insurance and may not ask you to pay anything toward the cost. The benefits are paid by an insurance carrier, or by the employer if it insures itself. Benefits are paid according to the law, and the Workers' Compensation Board ensures they are correctly provided.

The Workers' Compensation Board is a state agency that oversees how employers and insurers handle the claims of injured workers. A claim is paid if the insurer agrees the incident is work-related, or if the Board orders it. An employer or its insurer can dispute the claim. If that happens, the Board will try to resolve the dispute within 90 days. For example, the insurer may believe the incident didn't occur at work. It may not even agree that it covered your employer when you were hurt. Other issues may also arise. Whatever the reason, the Board will try to resolve it as quickly as possible.

You don't need to lose time from work to file a claim. No one needs to be found at fault for you to receive benefits. Claimants don't receive less if they were careless, nor do they receive more if the employer is at fault. However, a worker loses the right to benefits if the injury results solely from using drugs or alcohol, or from trying to injure herself or someone else.

### HOW TO FILE A CLAIM

*You must report the injury, in writing, to your employer within 30 days of the accident. **The Board must be notified of your case within two years of the accident.** You must also file a claim for compensation as soon as possible.*

*You may file Form C-3, Employee's Claim for Compensation, one of three ways.*

- 1. Online, click here to complete the form.*
- 2. Complete a paper C-3 and mail it to the nearest Board office. A C-3 is in the center of this pamphlet, and Board addresses are on the back.*
- 3. Call 1-866-396-8314. A Board representative will complete it with you.*

*You will be notified by mail if a hearing is necessary.*

**Who Is Covered?**

- Workers in all for-profit businesses.
- County and municipal employees.
- Public school aides, including New York City aides. New York City shop teachers are covered; other New York City teachers are covered in another system.
- Employees of the state of New York, including some volunteer workers.
- Domestic workers employed 40 or more hours per week by the same employer. This includes full-time sitters, companions, and live-in maids.
- Farm workers whose employer paid \$1200 or more for farm labor in the previous calendar year.
- Anyone else the Board determines is an employee.

Nonprofit entities, members of religious orders, employers of clergy and teachers, and domestic workers employed fewer than 40 hours a week may voluntarily carry coverage. It isn't mandatory.

**Who Isn't Covered?**

- People working at educational, religious or charitable institutions who don't teach or do manual labor.
- People covered by federal workers' compensation laws. This includes postal workers, certain maritime trades, interstate railroad, and federal employees.
- Anyone doing yard work or casual chores at a one-family, owner-occupied home. (A minor handling power-driven machinery, including a power lawn mower, is covered.) There may be coverage under a homeowner's policy.
- Certain foreign government employees.
- New York City police officers, firefighters, teachers and sanitation workers are covered by another system. Other uniformed police and firefighters may also be excluded.
- Real estate salespeople and media sales representatives who sign contracts stating that they are independent contractors.
- Sole proprietors, partners, and one/two person corporations with no employees may be covered but do not need it under the law.

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## A Worker's Responsibilities

1. Try to return to work as soon as you're physically capable. Your employer may have transitional or light duty work for you.
  2. You're responsible for looking for work within your physical abilities. This may mean working outside your previous occupation.
  3. Respond to all inquiries and documents from the Board and the insurer in a timely manner.
  4. Advise the Board and other parties of address changes.
  5. Attend all hearings and appointments. Arrive on time.
  6. Answer questions thoroughly and honestly.
  7. Participate actively in your case. Don't let events happen around you.
  8. Understand any agreements you make.
  9. Ask questions of your representative and the Board.
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## Medical Care

A worker who is injured on the job or becomes ill from his work will have his health care for that condition paid under a workers' compensation claim. This care is covered whether or not you lose time from work. It is also paid in addition to any benefits you get for missed wages.

Health care providers must be authorized by the Board to see workers' compensation patients. The Board has lists of providers who are authorized to treat you. You can find a doctor on [www.wcb.ny.gov/hps/HPSearch.jsp](http://www.wcb.ny.gov/hps/HPSearch.jsp), or by calling 1-800-781-2362. You can receive care from any of these providers, or from your own doctor, if he or she is registered.

The providers will send the bills directly to the insurer and the Board. **Do not pay any bills unless the Board disallows your case.** You may also receive reimbursement for travel to and from a health care provider's office.

If specific medical services are disputed, the insurer must pay any undisputed portion. It must also explain in writing why the services were not paid, and request any information needed to pay them. Your doctors may ask you to sign Form A-9. This states you'll pay the bills if the Board does not allow your claim, or if you drop your case before it's accepted.

### Preferred Provider Organizations

If the insurer has a network of providers to care for injured workers, you must use those providers. This is called a Preferred Provider Organization (PPO). The insurer must notify you of this. If you aren't satisfied with the care you receive from the PPO, you may select an authorized provider outside the PPO after 30 days of treatment.

### Diagnostic Networks

Insurers may also require you to use its network of facilities for diagnostic tests. Make sure to tell your doctors and other providers if the insurance carrier requires you to use its network for diagnostic test.

### Pharmacy Charges

You can go to any pharmacy, unless the insurer uses a network. Make sure the pharmacist knows you have a workers' compensation case, because many will bill the carrier directly, rather than you. However, the pharmacy can ask you to pay for the prescription up front. The insurer must reimburse you within 45 days. The pharmacy can only charge you the amount specified by law, so even if you pay in advance, you will be fully reimbursed. You're not responsible for a copayment.

If you must use an insurer's network pharmacy, the insurer must tell you how you should use it. Those pharmacies are paid directly. You will not be responsible for any charges.

### Exceptions

1. *Testing:* The insurer may not demand you use a network provider for a diagnostic test in a medical emergency. It may not demand you use a network that does not have a provider or facility within a *reasonable distance*, which is *one mile from your home or employment in an urban setting, and ten miles in a suburban or rural setting.*

2. *Pharmacy:* The insurer may not demand you use network pharmacies if it is not reasonably possible in a medical emergency. *You don't need to use network pharmacies if they don't offer mail order or aren't located a reasonable distance from you, either.*

## TYPES OF SERVICES COVERED

Medical  
Osteopathic  
Dental  
Podiatric  
Psychological  
(by referral)  
Chiropractic Treatment  
Surgery  
Hospital Care

Laboratory Tests  
Prescribed Drugs  
Nursing Services  
Surgical Appliances  
Prosthetic Devices

Preauthorization is  
sometimes required.

## Occupational Health Clinics

There are a number of occupational health clinics in New York that workers can use for diagnosis and treatment of workplace injuries and illnesses. See the list below, or visit <http://www.health.ny.gov/environmental/workplace/clinic.htm> for more information.

### Buffalo

Union Occupational Health Center  
716-668-8800

### Rochester

Finger Lakes Occupational Health Services of Univ. of Rochester Medical Center  
585-244-4771  
800-925-8615

### Syracuse/Utica/Binghamton

Central New York Occupational Health Clinical Center of SUNY Health Science Center  
315-432-8899

### Cooperstown, Specialty Clinic

New York Center for Agricultural Medicine and Health of Bassett Hospital, Cooperstown  
800-343-7527 or 607-547-6023

### Albany/Poughkeepsie/Glens Falls

Occupational and Environmental Health Center of Eastern New York  
800-419-1230 or 518-690-4420

### Westchester

Mt. Sinai-I.J. Selikoff Center for Occupational and Environmental Medicine  
914-964-4737

### New York City

Bellevue/NYU Occupational and Environmental Medicine Clinic of Health and Hospitals Corp.  
212-562-4572

### Long Island

Long Island Occupational and Environmental Health Center of SUNY Stony Brook  
631-444-6250

## **Rehabilitation and Social Work**

*Rehabilitation* services help people return to work, and to lead full and active lives. Specific services are explained below.

*Medical rehabilitation* helps people reach maximum independence and functioning. It provides workers with information and helps them obtain medical care, physical accommodation or other special needs. Only a physician may recommend medical rehabilitation, so talk to your doctor. This service is arranged outside the Board.

*Vocational rehabilitation* helps people whose disability prevents them from returning to their usual job. Counselors help injured workers find employment that fits their abilities. They also help develop a plan to return to work. This may include vocational counseling and referrals for training and selective job placement.

*Social workers* assist people when family or financial problems interfere with their returning to work. Social workers help people cope with their disability and discuss their concerns about rehabilitation. They can also help workers prepare to return to work.

The Board has counselors, social workers and claims examiners who coordinate and monitor other services. If you could benefit from these services, contact the Board. The office telephone numbers are on the back cover of this pamphlet.

## **Occupational Disease**

An occupational disease is contracted as the result of your work. It arises from a specific aspect of the work that you perform. For example, people who remove asbestos may contract asbestosis. People who work on computers may suffer carpal tunnel syndrome.

You may be disabled by an occupational disease even if you don't lose time from work.

The rules governing the time limits for filing an occupational disease claim are complex. You should file as soon as you know you're ill, or suspect that you have an occupational disease.

People disabled by occupational diseases receive the same benefits they would for an on-the-job accident. In the case of death, the dependents must file within two years of the date of death.

## **Occupational Hearing Loss**

The law states a different time period to file a claim for occupational hearing loss than from other disabilities. A waiting period must pass before you file a claim. That period is your choice of

- Three months after leaving the employment where you were exposed to the harmful noise, or
- Three months from the date you're removed from the harmful noise in the workplace. Removal can include wearing protective gear, so ask for it at work. You can contact OSHA at 1-800-321-OSHA for help if necessary.

The Board will consider the last day of whichever period you choose as the date of disability in determining when your benefits begin.

Occupational hearing loss claims have different time limits. You may file beyond the typical two-year limit if you do it within 90 days of learning the hearing loss is job-related.



## Wage Replacement (Cash) Benefits

Claimants who are totally or partially disabled for more than seven days receive benefits for lost wages. The amount you receive is based on your average weekly wage for the 52 weeks prior to the date of injury, including overtime. It's based on your gross earnings, not your take-home pay. The Board will use two-thirds of your average weekly wage, and then adjust it by the extent of your disability:

$$\mathbf{2/3 \times \text{average weekly wage} \times \% \text{ of disability} = \text{weekly benefit}}$$

The weekly maximum benefit is two-thirds your average weekly wage. If you suffer a total disability, you get two-thirds your weekly wage, up to the maximum (see below). For example, if you earn \$750 per week and are totally (100%) disabled as of today, you receive two-thirds of \$750, or \$500 per week. You're 100% disabled, so you receive all of the benefit.

If you're 50% disabled and earned \$750 per week, your benefit is \$250. To calculate it: two-thirds your \$750 average weekly wage equals \$500. Then, because you are 50% disabled, your benefit is half of \$500, or \$250.

The benefit rate is computed the same way, whether you are temporarily or permanently disabled. The maximum weekly wage benefit is based on accident date. It does not increase as maximum benefits increase.

<b>Date of Accident</b>	<b>Weekly Maximum Wage Benefit</b>
July 1, 1992 - June 30, 2007	\$400
July 1, 2007 - June 30, 2008	\$500
July 1, 2008 - June 30, 2009	\$550
July 1, 2009 - June 30, 2010	\$600
July 1 each succeeding year	2/3 of NYSAWW*

\* The New York State Average Weekly Wage is calculated on March 31 for the previous calendar year.

If you're disabled more than 14 days, you may get wage benefits from the first day. Otherwise, the first 7 calendar days of the disability are not covered. Medical care for your injury is provided as long as it's needed, as determined by the Board.

**Note: If the insurer disputes your case, it may withhold your wage replacement benefit until the Board directs it to pay you.**

## Reduced Earnings Benefits

If you can return to work but your injury keeps you from earning the same wages you once did, you may be entitled to a benefit that will make up two-thirds of the difference. These are reduced earnings benefits.

## Disability Classifications

Your doctor will state how much your injury disables you. The insurer may disagree with that judgment. That insurer can require you to see a doctor it chooses for an *independent medical exam*. The Board will decide how disabled you are (the *degree of disability*) from among those opinions. Your lost wage benefit is based on degree of disability. There are four classes.

**Temporary Total Disability** You cannot work and earn wages, but only on a temporary basis. You're entitled to the full allowable wage benefit.

**Temporary Partial Disability** You've temporarily lost some ability to work and earn full wages. You'll receive a percentage of your salary equal to the percentage of disability. For example, if you're 25% disabled, you'll get 25% of your award, for the time you're disabled.

Note: All injuries, even those later found *permanent*, are first *temporary*. All benefits are also subject to the maximum weekly amount.

**Permanent Total Disability** You completely lost the ability to work and earn wages. **There's no limit on the number of weeks of benefits.**

### **Permanent Partial Disability, Nonschedule Loss**

You lost some part of your ability to work. If you were injured before March 13, 2007, you can get benefits as long as the disability results in wage loss. Injuries after then may receive up to 10 years of benefits, as shown below. (You can apply for reclassification, and additional benefits, after that period.) Even if the disability doesn't impact wages, medical care is always paid.

### **Permanent Partial Disability, Schedule Loss**

This category involves loss of arm, hand, finger, leg, foot and toe or their use, and loss of eyesight or hearing. The law specifies the number of weeks in benefits you receive for this loss.

### **Disfigurement**

People whose faces, head or neck are permanently disfigured may get up to \$20,000, depending upon the extent of injury and date of accident.

## Resolving Disputed Claims

Insurers will often accept a claim and promptly begin paying benefits. However, an insurer can dispute a claim, for various reasons. It may not agree you were injured, it may not believe the injury occurred while it provided insurance, or any number of other situations. Board claims examiners and conciliators first attempt to resolve issues. If they can't, the Board will hold hearings in front of a workers' compensation law judge. The judge takes testimony, reviews your medical records and wages. Then, the judge decides the issue, and sets the amount of any award.

Either side may appeal that decision. This must be done in writing within 30 days of the decision. Three Board commissioners review appealed cases. They may agree, change part of a decision, or reject it. They may also return the case for more hearings. Insurers don't have to pay lost wage benefits while the case is being reviewed by the three commissioners. An insurer can accept part of a case and appeal another. In that instance, it must pay the accepted part of the award while the case is reviewed. The insurer must pay your wages and medical bills if your award is upheld by those commissioners, even if it appeals further.

Either side may appeal that decision, to the full Board of workers' compensation commissioners. If the full Board takes the case, it will either agree, change or overturn the decision.

Appeals from Board decisions may be taken within 30 days to the Appellate Division, Third Department, Supreme Court of the State of New York. That decision may be appealed in the Court of Appeals.

You always have the right to an attorney or licensed representative. That person may not ask for or take a fee from you. The Board determines the fee for legal services.

**That fee is deducted from the lost wages award.**

## Disability Benefits During a Dispute

If you aren't receiving benefits because your claim was disputed, you may get disability benefits in the meantime. You can file a DB-450 form, available by visiting

[www.wcb.ny.gov/content/main/forms/db450.pdf](http://www.wcb.ny.gov/content/main/forms/db450.pdf)

or by calling **1-800-353-3092**. You pay back any disability payments from your lost wage benefits.

## Death Benefits

There is a benefit for the family of workers who die from an injury or illness suffered on the job. The benefit is payable whether the worker dies right after an injury or later.

The worker's spouse and children will receive two-thirds of the employee's average weekly wage, up to the weekly maximum amount. The spouse and children share that weekly benefit; they do not each receive the full benefit. Children receive the benefit until age 18, or until 23 if they attend college. If a child is blind or physically disabled, he or she will receive the benefit for life. The spouse receives the benefit until remarriage. If the spouse remarries, he or she gets a final payment equal to two years of benefits.

The benefit is payable first to a spouse and minor children or dependent grandchildren. If there are no other dependents, then a different benefit is paid. The surviving parents or the deceased worker's estate may be entitled to \$50,000. Funeral expenses may also be paid. That benefit is up to \$6,000 in metropolitan New York counties, and up to \$5,000 in all others.

## Social Security Benefits

Your injury or illness may entitle you to Social Security Disability benefits, as well as workers' compensation. People with a permanent disability or a disability that lasts at least 12 months may qualify. Contact a Social Security Office to learn more.

## Discrimination

An employer may not fire you or hold it against you if you file a workers' compensation claim. You're also protected from retaliation for testifying in a workers' compensation case. Employers may not discriminate against you in hiring, too. You have two years to make a discrimination complaint. File Form DC-120 with the Board. You can call a Board office for the form, or find it at [www.wcb.ny.gov/content/main/forms/dc120.pdf](http://www.wcb.ny.gov/content/main/forms/dc120.pdf).

If the Board finds that a worker was improperly fired, it will order the employee restored. The employee will also receive back pay lost by that discrimination.

### AMERICANS WITH DISABILITIES ACT

The 1990 Americans with Disabilities Act prohibits discrimination against people with disabilities in employment. It ensures equal access to government services, public accommodations, transportation, and telecommunications. This law can help injured employees who want to return to work. Call the NYS Commission on Quality of Care and Advocacy for Persons with Disabilities at 1-800-949-4232 for more information.

## A Time line for Your Case

**Immediately:** Get medical treatment. Tell your supervisor about the accident and how it occurred. You must also notify your employer of the accident, in writing, within 30 days. You should file a C-3 form with the Board, too.

**Within 48 hours of treatment:** Your doctor files a medical report with the Board. Copies must also be sent to you and your representative, and to the employer or its insurance carrier.

**Within 10 days of accident notification:** The employer reports the injury to the Board and the insurer on Form C-2.

**Within 14 days of receiving Form C-2:** The insurer gives you a written statement of your legal rights within 14 days of learning of the accident or with the first check, whichever is earlier. If you must use its provider network, the insurer must also give you that contact information.

**Within 18 days of receiving Form C-2:** The insurer must accept your claim or explain why it disputes it. It must inform you, any representative and the Workers' Compensation Board. If you didn't notify the employer promptly, it must act within 10 days of learning of the accident. If the case is disputed and you're losing time from work, file for disability benefits.

**Every 2 weeks:** The insurer pays lost wage benefits to you (if the case is accepted). It will pay your healthcare providers directly. The insurer must notify the Board if it stops or modifies your benefits.

**Periodically:** See your doctor and get treatment as recommended. The doctor will submit progress reports to the Board and insurer.

## Common Questions about the Law

**Q. What is covered under Workers' Compensation Law?**

**A.** Injuries on the job and work-related illnesses, as well as occupational diseases.

**Q. What if I don't file a claim for workers' compensation?**

**A.** You may lose the right to benefits for lost wages and medical care. You should file a C-3 reporting your own injury or illness, even though your employer's insurer must notify this Board when it accepts or disputes your case.

**Q. How is the cash benefit for temporary total disability determined?**

**A.** The temporary total disability benefit is two-thirds of the average weekly wage you earned in the year before the accident. There is a maximum amount you can receive per week (see page 6). Your maximum benefit is set by what is in effect **on the date of the injury**.

**Q. Is medical care provided even if no time is lost from work?**

**A.** Yes. Medical care is provided for your condition even if no time is lost from work.

**Q. Must I wait for medical care?**

**A.** No, but physicians must request authorization to perform procedures that cost more than \$1,000 each. This \$1,000 threshold pertains to each procedure, not the total cost of care. Insurers must respond to the request within 30 days. Authorization is not necessary in case of an emergency.

## Common Questions about the Law (continued)

### Q. May a doctor treat me if the insurer does not answer a request for approval?

A. Yes. Insurers have 30 days to reply to an authorization request. If the insurer does not reply in 30 days, the provider may perform the services. If the service is a diagnostic test and the carrier requires claimants to use its network, the test must still be obtained from a network provider.

### Q. Are prescription medications covered under the law?

A. Yes. Once your claim is established, pharmacies may bill the insurer directly. You may receive a card or document you can show a pharmacy stating you have coverage. If the carrier has a pharmacy network, it will tell you, and you must use those pharmacies. The only exceptions are in a medical emergency, or if the pharmacies don't offer mail order and there isn't a location reasonably close to you. You may have to pay the pharmacy for service before your claim is established. The carrier must then pay you when the case is established. There is no copayment.

### Q. What happens when an insurance carrier contests a claim?

A. To contest a claim, a carrier must notify the Board within 18 days of the disability, or within 10 days of learning of the accident, whichever is later. The carrier must explain why it disputes the claim. You are then entitled to present your case to the Board. You will be notified of a pre-hearing conference. The Board seeks to resolve most cases within 90 days.

### Q. Must I have a medical examination when the employer or insurer requests it?

A. Yes. The insurer may have you examined by a qualified provider who is authorized by this Board, within a reasonable distance for you to travel. Refusing this exam may affect your claim.

### Q. May an insurer suspend or change the cash benefits?

A. Yes, but you are then entitled to a hearing. A carrier must submit evidence for the change to the Board, and the Board decides. A carrier may not change your benefit after the Board decides it without the Board's approval.

### Q. Do I have to use an attorney?

A. No, but an attorney can be helpful in disputed and complex cases. You may represent yourself, or use an attorney or a licensed representative (list of licensed representatives is found at [www.wcb.ny.gov/content/main/Reps/LisRepListing-Sec24a.pdf](http://www.wcb.ny.gov/content/main/Reps/LisRepListing-Sec24a.pdf)). Any fees are approved by the Board, and deducted from your award. **Do not pay your counsel directly.**

### Q. What can I do if I disagree with the Board's decision?

A. You may appeal in writing within 30 days of the filing date of the decision. You must explain why you disagree with the decision. Three Board commissioners will review your case. If you disagree with that review, you can appeal to the full Workers' Compensation Board of Commissioners. They may or may not consider it.

### Q. What can I do if I'm not satisfied with the outcome of the appeal?

A. You may appeal to the Appellate Division, Third Department, within 30 days after the decision is served.

### Q. Are there penalties for falsehoods in claims?

A. It's a felony to willfully misrepresent a case to obtain benefits. Penalties include up to seven years imprisonment and fines. A claimant may also lose the right to benefits. It's also a felony for an insurer to raise a false issue in an attempt to deny a worker benefits it knows the worker is entitled to receive.

## Directory of WCB Services and Board Offices

### *Board Services*

#### **Customer Service**

1.877.632.4996

#### **Advocate for Injured Workers**

1.800.580.6665

#### **Health Care Provider**

1.800.781.2362

#### **Administrative Review**

##### **Division**

1.877.258.3441

#### **Fraud Referral Hotline**

1.888.363.6001

#### **Disability Benefits**

1.800.353.3092

### *Board Offices*

#### **Albany District Office**

100 Broadway - Menands

Albany, NY 12241

1.866.750.5157

#### **Binghamton District Office**

State Office Bldg., 44 Hawley Street

Binghamton, NY 13901

1.866.802.3604

#### **Buffalo District Office**

Cyclorama Building

369 Franklin Avenue

Buffalo, NY 14202

1.866.211.0645

#### **Rochester District Office**

130 Main Street West

Rochester, NY 14614

1.866.211.0644

#### **Syracuse District Office**

935 James Street

Syracuse, NY 13203

1.866.802.3730

**Send mail for these upstate districts  
directly to these addresses.**

#### *Brooklyn District Office*

111 Livingston Street

Brooklyn, NY 11201

1.800.877.1373

#### *Hauppauge District Office*

220 Rabro Drive, Suite 100

Hauppauge, NY 11788-4230

1.866.681.5354

#### *Hempstead District Office*

175 Fulton Avenue

Hempstead, NY 11550

1.866.805.3630

#### *Manhattan District Office*

215 W. 125th Street

New York, NY 10027

1.800.877.1373

#### *Peekskill District Office*

41 North Division Street

Peekskill, NY 10566

1.866.746.0552

#### *Queens District Office*

168-46 91st Avenue

Jamaica, NY 11432

1.800.877.1373

Claims-related mail for these  
districts should go to the *downstate*  
*centralized mailing address:*

**PO Box 5205 • Binghamton, NY •  
13902-5205**



# 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.ny.gov](http://www.wcb.ny.gov).

WCB Case Number (if you know it): \_\_\_\_\_

### A. YOUR INFORMATION (Employee)

1. Name: \_\_\_\_\_ 2. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First MI Last
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): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



YOUR NAME: \_\_\_\_\_  
First MI Last

DATE OF INJURY/ILLNESS: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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)  
State of New York - Workers' Compensation Board**

**C-3.3**

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



## 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.ny.gov/>

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

**Buffalo DO - 295 Main Street, Suite 400, Buffalo NY 14203 (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)

**C-3.0 (1-11)**

**State of New York**  
**WORKERS' COMPENSATION BOARD**

**CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS**  
 (Pursuant to Workers' Compensation Law Section 110-a)

**PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.**

Claimant's Name	Claimant's Social Security No.	Case Number and/or Date of Accident	<input type="checkbox"/> WCB	<input type="checkbox"/> DB	<input type="checkbox"/> Discrimination
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IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).

**CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.**

**INSTRUCTIONS:**  
 Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, \_\_\_\_\_, \_\_\_\_\_  
Claimant's Name

represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to \_\_\_\_\_, at \_\_\_\_\_  
Name of a Specific Person, Corporation, Association or Public or Private Entity

\_\_\_\_\_  
Address

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

\_\_\_\_\_  
 Claimant's Signature (ink only -- use blue ballpoint pen if possible) \_\_\_\_\_ Date \_\_\_\_\_

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

Pursuant to Workers' Compensation Law Section 110-a:

3. Individual authorization. Notwithstanding the restrictions on disclosure set forth under subdivision one of this section, a person who is the subject of a workers' compensation record may authorize the release, re-release or publication of his or her record to a specific person not otherwise authorized to receive such record, by submitting written authorization for such release to the board on a form prescribed by the chair or by a notarized original authorization specifically directing the board to release workers' compensation records to such person. However, in accordance with section one hundred twenty-five of this article, no such authorization directing disclosure of records to a prospective employer shall be valid; nor shall an authorization permitting disclosure of records in connection with assessing fitness or capability for employment be valid, and no disclosure of records shall be made pursuant thereto. It shall be unlawful for any person to consider for the purpose of assessing eligibility for a benefit, or as the basis for an employment-related action, an individual's failure to provide authorization under this subdivision.

4. It shall be unlawful for any person who has obtained copies of board records or individually identifiable information from board records to disclose such information to any person who is not otherwise lawfully entitled to obtain these records.

5. Any person who knowingly and willfully obtains workers' compensation records which contain individually identifiable information under false pretenses or otherwise violates this section shall be guilty of a class A misdemeanor and shall be subject upon conviction, to a fine of not more than one thousand dollars.

6. In addition to or in lieu of any criminal proceeding available under this section, whenever there shall be a violation of this section, application may be made by the attorney general in the name of the people of the state of New York to a court or justice having jurisdiction by a special proceeding to issue an injunction, and upon notice to the defendant of not less than five days, to enjoin and restrain the continuance of such violations; and if it shall appear to the satisfaction of the court or justice that the defendant has, in fact, violated this section, an injunction may be issued by such court or justice, enjoining and restraining any further violation, without requiring proof that any person has, in fact, been injured or damaged thereby. In any such proceeding, the court may make allowances to the attorney general as provided in paragraph six of subdivision (a) of section eighty-three hundred three of the civil practice law and rules, and direct restitution. Whenever the court shall determine that a violation of this section has occurred, the court may impose a civil penalty of not more than five hundred dollars for the first violation, and not more than one thousand dollars for the second or subsequent violation within a three year period. In connection with any such proposed application, the attorney general is authorized to take proof and make a determination of the relevant facts and to issue subpoenas in accordance with the civil practice law and rules.