

Instructions for Completing Form C-2, "Employer's Report of Work-Related Injury/Illness"

Please complete this form and send it directly to your local Workers' Compensation Board district office (DO). The addresses are listed at the bottom of page 3. Also send a copy of the form to your insurance carrier. If you need additional help in completing this form, you may contact the Workers' Compensation Board at **1-877-632-4996** or visit **<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 the form. Fill out the Date of Injury/Illness, to the best of your knowledge, and the Date of this Report at the top of page 1. Remember to enter in the name of the injured employee and the date of injury/illness on the top of page 2 and page 3.

Section A - Employer Information:

- Item 1:** Indicate the name of the company or the owner's name and DBA name.
- Item 2:** Enter the employer's Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number.
- Item 3:** Enter the employer's main address where you receive mail (such as a central office). Include P.O. Boxes.
- Item 4:** Enter the physical address of the employer (if different).
- Item 5:** Enter the primary contact phone number for the employer, including area code.
- Item 6:** Indicate the North American Industry Classification System (NAICS) or Standard Industrial Classification (SIC) Code for your business. If you do not know your NAICS or SIC Code, please indicate the type or nature of business as accurately as possible (e.g., Restaurant, Construction, Retail).
- Item 7:** Enter the OSHA Case Number, if known.
- Item 8:** Enter the first 7 digits of your New York Unemployment Insurance (NY UI) Registration Number (UIER). This is the number used to report to the Department of Labor.

Section B - Insurance Carrier / Self-Insured Employer:

- Item 1:** Indicate the Carrier Code Number (W Number) issued by the Workers' Compensation Board. If you do not know the W number, contact your insurance carrier. *If you are self-insured, only enter your Carrier Code Number (W Number) and skip to Section C.*
- Item 2:** Enter the name of the employer's Workers' Compensation Insurance Carrier or Group Name. If you do not know your insurance carrier, please indicate the employer's Insurance Agent Name for item 4 and the Agent's contact phone number for item 5.
- Item 3:** Enter your Workers' Compensation Insurance Policy Number and indicate the policy effective period for coverage at the time of the injury or illness.
- Item 4:** Insurance Agent Name if the carrier is unknown.
- Item 5:** Insurance Agent phone number, including the area code.

Section C - Employee's Personal Information:

- Item 1:** Indicate the injured employee's full legal name.
- Item 2:** Enter the employee's date of birth.
- Item 3:** Enter the employee's mailing address, including street number, P.O. Box (if applicable), Town or City, State, and Zip Code.
- Item 4:** Indicate the employee's Social Security Number (SSN).
- Item 5:** Enter a contact phone number for the employee, either a home phone number or a cell phone number, including the area code.
- Item 6:** Indicate his/her gender.

Section D - Employee's Injury or Illness:

If this is an illness or occupational disease and an exact date of illness cannot be determined, then skip items 1 and 2.

- Item 1:** Indicate the time of day when the employee began work on the day the injury occurred.
- Item 2:** Enter the time when the injury occurred.
- Item 3:** Check whether the employee has given notice of his/her injury or illness to the employer. If so, enter the date notice was given and if it was orally or in writing. If written notice was given, please attach a copy of the employee's notice as well as any medical notes you may have received. Also attach the [supervisor's] incident report, if available.
- Item 4:** Check whether you gave the employee a Claimant Information Packet and if so, when.
- Item 5:** 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 6:** Check if this was the employee's normal work location. If it was not, explain why the employee was at this location.
- Item 7:** Enter the name of the employee's direct supervisor.
- Item 8:** Indicate whether the supervisor was a witness to the injury/illness.
- Item 9:** Check if anyone else witnessed the injury/illness and if so, list their name(s).

Section D - Employee's Injury or Illness (cont.):

- Item 10:** Describe in detail what the employee was 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 11:** Describe in detail how the injury/illness occurred (e.g., the employee was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
- Item 12:** Indicate fully the nature and extent of the employee's injury/illness, including all body parts injured. Be as specific as possible (e.g., lumbar gluteal muscle strain resulting from sudden straining).
- Item 13:** 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 14:** Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was the employee's, the employer's, or that of a third party and include the license plate number (if known). If the employer's vehicle was involved, fill out the automobile liability insurance carrier for the vehicle and their address.
- Item 15:** Check if the injury/illness resulted in the death of the employee and if so, indicate the date of death and the nearest relative of the deceased (if known).

Section E - Medical Treatment:

- Item 1:** If the employee did not receive medical treatment for this injury/illness, check None Received and skip to item 4. Otherwise, enter the date the employee first started treatment for this injury/illness, or check Unknown if you do not know, and complete the rest of this section.
- Item 2:** Check the location where initial medical treatment was administered for this injury/illness and whom was responsible for treatment/care of the employee (e.g., Physician, Nurse, EMT, etc.). Include the name of the person and the facility.
- Item 3:** If the employee is still receiving ongoing treatment for the same injury/illness, check Yes and indicate the name and address of the physician providing treatment; otherwise check No or Unknown.
- Item 4:** If the employee had a similar work-related injury to the same body part or a similar work-related illness while working for the same employer, check Yes and if known, indicate the name and address of the physician whom provided care; otherwise check No.

Section F - Return To Work:

- Item 1:** If the employee has stopped working as a result of the work-related injury/illness, check Yes and indicate on what date he/she stopped working.
- Item 2:** If the employee has since returned to work, check Yes. Also indicate on what date the employee started working again, as well as if the employee has returned to his/her Normal Duties or if the employee is on Limited or Restricted Duty. (If the employee has not returned to his/her full pre-injury or illness work duties, then the employee is on Limited Duty).
- Item 3:** If the employee has returned to work on Limited Duty, enter in his/her average gross earnings per week.

Section G - Employee's Work Information:

- Item 1:** Indicate the date the employee was hired by the employer.
- Item 2:** Enter the employee's current job title.
- Item 3:** Describe the employee's typical work activities or enter the employee's job description. If you need more space, you may attach an official job description or additional pages to completely and accurately describe the employee's work activities.

Section H - Employee's Payroll Information:

- Item 1:** Enter the employee's average gross weekly pay before the injury/illness.
- Item 2:** Check if the employee received any tips or lodging in addition to his/her regular pay and if so, describe them.
- Item 3:** Check the type of job the employee had.
- Item 4:** Check which days of the week the employee usually worked. If the employee did not work a standard work week, please explain in Section I or attach an additional page or work schedule in order to fully explain.
- Item 5:** Check if the employee was paid for a full day's work on the day of the injury/illness.
- Item 6:** Indicate if the employee continued to receive pay after the illness/injury, such as sick leave or disability pay.

Section I - Additional Information:

Enter any additional information that may be relevant to the employee's work-related injury/illness in this section. You can also use this area to further explain other items in this form, such as G-3 or H-4.

Sign Form C-2 on the last page. If the form was filled out by a third-party on behalf of the employer, that person should sign on the second signature line.