STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

EMPLOYEE'S CLAIM FOR COMPENSATION

ANSWER ALL QUESTIONS FULLY - PRINT OR TYPE CLEARLY

IMPORTANT: Your Social Security Number Must Be Entered:
IMPORTANTE: El Numero de su Seguro Social Debe Ser Indicado: ☐☐☐ ☐☐ ☐☐☐☐

WCB Case No. (If known)_____ Carrier Case No.(if known)_____

A. Injured person	1. Name..... (First Name, Middle Name, Last Name) 2.MailingAddress..... (Number and Street (includeApartment No.), City, State, Zip Code) 3. Sex ☐Male ☐Female Age.....Date of Birth.....Telephone No. ( )..... 4. Do you speak English? ☐ Yes ☐ No If no, what language do you speak?..... 5. Name of union and local number, if member..... 6. State what your regular work/occupation was..... 7. Wages or average earnings per day, including overtime, board, rent and other allowances..... 8. Were you paid full wages for the day of injury? ☐ Yes ☐ No 9. Your work week at time of injury was☐ Five day☐ Six day☐ Seven day☐ Other.....
B. Employer(s)	1. Employer.....Telephone No. ( )..... 2. Employer's Address..... 3. Were you employed by any other employer or employers at the time of your injury/illness? ☐ Yes ☐ No 4. If yes, did you lose time from work at this other employment as a result of your injury/illness? ☐ Yes ☐ No
C. Place/Time	1. Address where injury occurred.....County..... 2. Date of Injury.....at.....o'clock, ☐ AM ☐ PM
D. The Injury	1. How did injury/illness occur?..... ....
E. Nature and Extent of Injury/ Illness	1. State fully the nature of your injury/illness, including all parts of body injured..... ..... 2. Date you stopped work because of this injury/illness?..... 3. Have you returned to work? ☐ Yes ☐ No If yes, on what date?..... 4. Does injury/illness keep you from work? ☐ Yes ☐ No 5. Have you done any work during period of disability? ☐ Yes ☐ No 6. Have you received any wages since your injury/illness? ☐ Yes ☐ No
F. Medical Benefits	1. Did you receive or are you now receiving medical care? ☐ Yes ☐ No 2. Are you now in need of medical care? ☐ Yes ☐ No 3. Name of attending doctor..... Doctor's address..... 4. If you were in a hospital, give the dates hospitalized..... Name of hospital..... Hospital's Address.....
G. Comp. Payments	1. Have you received or are you now receiving workers' compensation payments for the injury reported above? ☐ Yes ☐ No 2. Do you claim further workers' compensation payments? ☐ Yes ☐ No
H. Notice	1. Have you given your employer (or supervisor) notice of injury? ☐ Yes ☐ No 2. If yes, notice was given ☐ orally ☐ in writing, on..... to .....

I hereby present my claim to the Chair, Workers' Compensation Board, for compensation for disability resulting from an accidental injury or occupational disease arising out of and in the course of my employment and not occasioned by my willful intention or solely through intoxication, and in support of it I make the foregoing statement of facts.

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.

Signed by..... Dated.....
(Claimant)

SEE OTHER SIDE FOR IMPORTANT INFORMATION - VEASE AL DORSO PARA INFORMACION DE IMPORTANCIA

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 participating in the NYS Managed Care Pilot Program or is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the certified managed care organization or 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. You are entitled to a hearing. You are not required to obtain anyone to represent you at a hearing, but you have the right to be represented by an attorney or licensed representative, if you so choose. If you obtain representation, do not pay your attorney or representative directly. When the Workers' Compensation Board rules on your case, the attorney's or representative's fee will be set by the Board and paid to him or her by your employer or by your employer's insurance carrier. The amount so paid will be deducted from your award.
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.

LO QUE TODO TRABAJADOR DEBE HACER EN CASO DE LESION O ENFERMEDAD OCUPACIONAL.

1. Avisar inmediatamente a su patrono ó a su supervisor cuando, donde y como sufrio la lesión.
2. Obtener atención médica inmediatamente.
3. Pedirle a su médico que presente informes a la Junta y a su patrono, ó a la compañia de seguros.
4. Llenar esta forma de reclamación para compensación y enviarla a la oficina mas cercana de la Junta de Compensación. (vease abajo.) El no presentar reclamación dentro de dos años a partir de la fecha de la lesión puede ser motivo de que se le rechace la reclamación. Si necesita que le ayuden a llenar esta forma, llame por telefono o vaya a la oficina mas cercana de la Junta de Compensación Obrera.
   Acudir a todas las audiencias cuando se le notifique que comparezca.
5. Volver a su trabajo lo mas pronto que le sea posible; la compensación nunca es tan alta como su sueldo.

SUS DERECHOS:

1. Por lo general usted tiene derecho a ser atendido por el médico de su preferencia, siempre y cuando esté autorizado por la Junta. Si su patrono participa del Programa Piloto de Gerencia de Salud del Estado de Nueva York o está participando en un acuerdo de organización de proveedores con preferencia (P.P.O.) su tratamiento inicial deberá obtenerlo de la entidad que su patrono haya designado para proveer cuidado médico para lesiones relacionadas con la compensación obrera.
2. NO PAGUE NADA a su médico ni al hospital. Esas facturas seran pagadas por la compañia de seguros si su caso no ha sido cuestionado. Si el caso es disputado, su médico y el hospital deberan esperar hasta que la Junta decida el caso. Si usted dejara de proseguir su caso o si la Junta fallara en su contra,
   le corresponde pagar a su médico y al hospital.
3. Tambien tiene usted derecho a ser reembolsado por gastos de medicamentos, muletas o cualquier aparato apropiadamente prescrito por su médico y por transportación u otros gastos necesarios para visitar el consultorio de su médico ó el hospital. (obtenga comprobantes de esos gastos.)
4. Usted tiene derecho a compensación si su lesión le deja impedido de trabajar por mas de siete dias, o le obliga a trabajar a sueldo mas bajo ó resulta con incapacidad permanente en alguna parte de su cuerpo.
5. La compensación es pagadera directamente y sin tener que esperar la decisión, excepto cuando se cuestione la reclamación.
6. Usted tiene derecho a una audiencia. Usted no está obligado a conseguir quien le represente en la audiencia, pero tiene derecho a ser representado por un abogado o por un representante licenciado, si usted lo prefiere. En caso de obtener usted representación, no pague nada directamente a su abogado o representante. Cuando la Junta de Compensación Obrera decida su caso , los honorarios de su abogado o representante seran fijados por la Junta y seran pagados por el patrono ó por la compañia de seguros. La suma pagada en esta forma sera deducida de la cantidad adjudicada a usted.
7. Si necesita ayuda para volver al trabajo, ó si tiene problemas familiares o economicos por motivo de su lesión, comuniquese con la oficina de la Junta de Compensación Obrera que le quede mas cerca y pida una reunión con un consejero de rehabilitación o con un trabajador social.

WORKERS' COMPENSATION BOARD DISTRICT OFFICES AND COUNTIES SERVED
OFICINAS DE DISTRITO DE LA JUNTA DE COMPENSACION OBRERA Y LOS CONDADOS SERVIDOS

ALBANY 12241 - 100 Broadway, Menands. (518) 474-6674 For all accidents in following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, , Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington.

BINGHAMTON 13901 - State Office Building, 44 Hawley Street. (607) 721-8356 For all accidents in following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins.

BUFFALO 14202 - Statler Towers, 107 Delaware Ave. (716) 842-2166 For all accidents in following counties: Cattaraugus, Chautauqua, Erie, Niagara.

ROCHESTER 14614 - 130 Main Street West. (716) 238-8300 For all accidents in following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates.

SYRACUSE 13203 - 935 James Street. (315) 423-2932 For all accidents in following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence.

DOWNSTATE CENTRALIZED MAILING (for New York City, Hempstead, Hauppauge & Peekskill district offices) - PO Box 29017, Brooklyn, NY 11202-9017. NYC (800) 877-1373 Hemp. (516) 560-7700 Haup. (631) 952-6000 Peek. (914) 788-5775 For all accidents in following counties: Bronx, Kings, Nassau, New York, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester.

(Claims for compensation, inquiries, medical and other reports should be sent to the District Office of the County in which the accident occurred. Be sure to notify this office of any change in your address.)

PRIVACY LAW NOTIFICATION

The authority to request this personal information and all future information is found in Sections 20, 117 and 141 of the Workers' Compensation Law. The principal purpose for which information is collected is to assist the Workers' Compensation Board in determining your eligibility for workers' compensation benefits.

The information will be used by the officers and employees of this agency as well as any other party to the case to assist in the adjudication and determination of the claim and for disclosure under the Freedom of Information Law, Public Officers Law, Article 6.

Failure to provide the requested information may delay the processing of your claim or result in the denial of your claim.

This information will be maintained by the Privacy Compliance Officer, Office of the General Counsel, Workers' Compensation Board, 100 Broadway-Menands, Albany, New York 12241, (518)486-9564.

The Workers' Compensation Board assures hearing locations accessible to the disabled. Contact the nearest Board office if you have special accessibility needs.

(Reclamaciones para compensación, preguntas, informes medicos y de otra naturaleza deben enviarse a la oficina de distrito del condado donde ocurrio el accidente. No deje de avisar a esta oficina acerca de cambios en su dirección.)

NOTIFICACION DE LA LEY DE PRIVACIDAD

Las secciones 20, 117, y 141 de la ley de Compensación Obrera, autoriza el requerimiento de información personal relacionada con una reclamación pendiente. Dicha información se recopila con el proposito de asistir a la Junta de Compensación Obrera, en la determinación sobre su elegibilidad para recibir los beneficios compensatorios.

La información requerida sera utilizada por los oficiales y empleados de la agencia, asi como por cualquier parte en el caso, para asistir en la adjudicación y determinación de la reclamación. Tambien puede ser obtenida la información de referencia, bajo la ley de Libre Información y la ley de Oficiales Publicos, Articulo 6.

Si usted no provee la información requerida, ello puede tardar el tramite de su reclamación o producir la denegación de dicha reclamación.

La información requerida, sera mantenida bajo la custodia de la oficial de Cumplimiento de Privacidad, Oficina del Consejero General, de la Junta de Compensación Obrera en 100 Broadway-Menands, Albany, New York 12241, (518) 486-9564.

Proveemos locales accesibles para la vista de sus casos. Comunicate con nuestra oficina mas cercana si tienes algun requerimiento especial de acceso.

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 29017 Brooklyn, NY 11202-9017
NYC (800)877-1373 / Hemp. (516)560-7700 / Haup. (631)952-6000 / Peek. (914)788-5775

100 Broadway Menands ALBANY 12241 (866) 750-5157

State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604

Statler Towers 107 Delaware Ave. BUFFALO 14202 (866) 211-0645

130 Main Street W. ROCHESTER 14614 (866) 211-0644

935 James St. SYRACUSE 13203 (866) 802-3730

State of New York
WORKERS' COMPENSATION BOARD
CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS
(Pursuant to Workers' Compensation Law Section 110-a)

Claimant's Name	Claimant's Social Security No.	Claimant's Current or Most Recent WCB Case No. if any	Date of Accident for this Case

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILES, CHECK ONE BOX:
☐ Any and All Other Case Files for this Claimant
☐ Individual Claimant Case File(s) identified below (give WCB Case No. and date of accident for each):

Records Authorized for Release:
☐ Entire file(s)
☐ Specific Document(s) - give details below

Reason for Disclosure of Records (optional)

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 eCASE ACCESS.

Pursuant to Section 110-a of the Workers' Compensation Law, I, _____, 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

Claimant's Name

_____, at

Name

_____.

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) 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.

PATIENT REGISTRATION FORM

Please fill out completely

Mr./Ms./Mrs. (Please circle one)

Name: _____ _____ / _____ / ____
First Middle Last Date of Birth

Home Address: _____ _____
Street Social Security No.

_____ Sex (please circle): M F
City State Zip Code

Home Phone: _____ Work Phone: _____

Cell: _____ E-mail: _____

Employer's Name, Address & phone#: _____

Occupation: _____

Referred By: _____ Primary Care Dr.: _____

Referring Dr. Phone #: _____ Primary Care Dr. Phone #: _____

Part of Body Injured: _____ Date of Injury/First Symptom: _____

How were you injured?: _____

Have x-rays been taken
within the past 6 months? Yes___ No___ If yes, where: _____
Name City State

Emergency Contact: _____ Phone: _____

We require cash payment on the day you are treated, if you are not covered by a current health insurance policy. If you are a member of a health maintenance organization (HMO) or a preferred physician organization (PPO), please give us your insurance card to copy for our files.

WE REQUIRE CO-PAYMENT ON THE DAY YOU ARE TREATED

Insurance Company: _____ Group #:_____

Insurance Company Address: _____

Name of Insured: _____ Insured SS#: _____

Relationship to Patient: _____ If Applicable, Medicare #: _____

Secondary Insurance Co.: _____

Secondary Insurance ID#: _____

Signature: _____ Date: _____

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

In the event I fail to prosecute the claim for workers' compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable workers' compensation case, I,_____, hereby agree to pay (name)_____(address)_____ his/her usual and customary fees for services rendered to the above named claimant in the above identified case.

Date:_____ Signature_____

If signed by other than claimant, print below the name, address, and relationship of signer.

Name and Address_____ Relationship_____