

Employer's First Report of Work-Related Injury/Illness

A work-related injury or illness must be reported within 10 days (Per Section 110) of the injury/illness or be subject to a penalty. Employers are not required to submit form C-2F to the Workers' Compensation Board if the employer's insurer will be submitting the accident information electronically to the Board on the employer's behalf. If you need assistance completing this form, please contact your insurer for guidance on the best method of reporting work-related accident information. If you submit this form to the Board, please send it to P.O. Box 5205, Binghamton, NY 13902 and provide a copy to your insurer.

Employee Name _____**WCB Case Number (JCN)** _____ **Date of Injury** _____**Claim Administrator Claim Number** _____**INSURER / CLAIM ADMINISTRATOR INFORMATION****Insurer Name** _____ **Insurer ID** _____**Name** _____**Info/Attn** _____**Address** _____**City** _____ **State** _____**Postal Code** _____ **Country** _____**Claim Admin ID** _____**EMPLOYEE INFORMATION****First Name** _____ **Middle Name/Initial** _____**Last Name** _____ **Suffix** _____**Mailing Address** _____**City** _____ **State** _____**Postal Code** _____ **Country** _____**Phone Number** _____ **Date of Hire** _____**Date of Birth** _____ **Gender** Male Female Unknown**Employee SSN** _____**Occupation Description** _____

CLAIM INFORMATION

Time of Injury _____ Date Employer Had Knowledge of the Injury _____
Employment Status _____ Date Employer Had Knowledge of Date of Disability _____
Estimated Weekly Wage _____ Number of Days Worked Per Week _____
Work Week Type Standard Work Week Fixed Work Week Varied Work Week
Work Days Scheduled Sun Mon Tues Wed Thurs Fri Sat

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes No Employer Paid Salary in Lieu of Compensation Yes No
Initial Treatment No Medical Treatment Minor On-Site Treatment By Employer Minor Clinic/Hospital Treatment
 Emergency Evaluation Hospitalization Greater Than 24 Hours Future Major Medical/Lost Time Anticipated
Death Result of Injury Yes No Unknown Date of Death _____ Number of Dependents _____
Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc) _____
Part of Body (i.e. left arm, right foot, head, multiple, etc) _____
Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc) _____
Accident/Injury Description (see instructions)

WORK STATUS

Initial Date Last Day Worked _____ Return To Work Type Actual Released
Initial Date Disability Began _____ Physical Restrictions Yes No
Initial Return to Work Date _____ Return To Work Same Employer Yes No

ACCIDENT LOCATION AND WITNESSES

Premises (see instructions) Employer Lessee Other
Organization Name _____
Street _____ State _____
City _____ Postal Code _____
County _____ Country _____
Location Narrative _____

Witnesses

Business Phone Number

EMPLOYER INFORMATION

Name _____ Employer FEIN _____
UI Number _____ Manual Classification Code _____
Industry Code _____
Info/Attn _____
Mailing Address _____
City _____ State _____
Postal Code _____ Country _____
Physical Addr _____
City _____ State _____
Postal Code _____ Country _____
Contact Name _____
Contact Business Phone Number _____

INSURED INFORMATION

Insured Name _____ Insured FEIN _____
Insured Type Insured Self-Insured Uninsured Insured Location ID _____
Policy Number ID _____
Policy Effective Date _____ Policy Expiration Date _____

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

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

If prepared by the employer:

Signature of Person Preparing Form _____ Date _____
Print Name _____
Title _____ Phone Number _____