

First Report of Injury Filing Guide

To report a claim please call your First Report of Injury response line at
1-888-785-7755 ext. 8813/8815

Your representative will need the information on this form to properly process your claim.
 Please use this form as a guide.

Employer Information:

Employer:	Employer FEIN:
Address:	NY UI Employer Reg #:
Location of Accident:	WC Policy #:
Phone #:	Nature of Business:
Email Address:	Supervisor's Name:

Claimant/Employee:

Name:	D.O.B.:
Home Address:	Job title:
City, St, Zip	Related to Employer Y/N Relationship:
Phone #:	Hire date:
SS #:	Male or Female:

Payroll Information:

Amount Paid last 52 weeks:
Average Weekly Wage:
Employee's Job was (check one): Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer <input type="checkbox"/> Other <input type="checkbox"/>
Work Week (days worked): M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> Sat <input type="checkbox"/> Sun <input type="checkbox"/>
Was the employee paid for a full day on the day of the injury/illness? Yes <input type="checkbox"/> No <input type="checkbox"/>
Did the employee receive lodging or tips in addition to pay Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, describe:
Last date worked: / / Last date paid: / / In Full? Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you continue to pay the employee after the injury/illness (e.g. sick leave, vacation, disability, regular salary)? Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, is reimbursement requested? Yes <input type="checkbox"/> No <input type="checkbox"/>

Accident Information:

Date of Accident: / / Time of Accident: AM <input type="checkbox"/> PM <input type="checkbox"/>
Time employee began work on Date of accident: AM <input type="checkbox"/> PM <input type="checkbox"/>
Has the employee given you notice of injury/illness? Yes <input type="checkbox"/> No <input type="checkbox"/>
Date notice provided / / If Yes, Name & Title of person to whom accident was reported: Oral <input type="checkbox"/> Written <input type="checkbox"/>
His or Her Phone#
Address where Accident occurred: Assured address? Yes <input type="checkbox"/> No <input type="checkbox"/>
If No, please give address where accident occurred:
Was this location where the employee normally worked? Yes <input type="checkbox"/> No <input type="checkbox"/>
If No, why was employee there?
Did Supervisor see injury happen? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Did anyone else see injury happen? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
If yes, name of witness and position
Please provide a full description of the incident leading to the employee's illness or injury: _____
What body parts affected?
Was an object (e.g. forklift, hammer, acid) involved in injury/illness? Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, what was it?
Was the injury the result of the use or operation of a licensed motor vehicle? Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes: Employee's vehicle <input type="checkbox"/> Employer's vehicle <input type="checkbox"/> Another vehicle <input type="checkbox"/>

License plate number (if known)
Auto Insurance information:
Did the injury/illness result in the employee's death? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, what was the date of death? ____/____/____
Have you given the employee a claimant information packet? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give date: ____/____/____
Are you disputing the accident? If so, why?

Return to Work:

Did the employee lose more than one day or more shift because of his/her injury/illness? Yes or No
If yes, what was the last date the employee worked?
What was the first scheduled work day or work shift they missed after the accident?
When did the employer become aware that the employee's lost time was due to his/her injury/illness?
Did employee lose more than or is anticipated to lose more than one week of work? Yes or No
Light duty available? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is claimant/employee back to work? Yes <input type="checkbox"/> No <input type="checkbox"/> Date of return to work: ____/____/____
Full Pay? Yes <input type="checkbox"/> No <input type="checkbox"/> If No, average gross earnings?

MEDICAL TREATMENT INFORMATION:

Date of employee's first medical treatment: ____/____/____ None received <input type="checkbox"/> Unknown <input type="checkbox"/>
Where did the employee receive first medical treatment for this injury/illness? Onsite <input type="checkbox"/> Doctor's office <input type="checkbox"/> Emergency Room <input type="checkbox"/> Clinic/Hospital/Urgent Care <input type="checkbox"/> Hospital stay over 24hours <input type="checkbox"/> Unknown <input type="checkbox"/>
Who treated the employee and where?
Doctor Name:
Hospital/Clinic Name (if applicable):
Address: _____ Telephone: _____
Number of Doctor/Hospital visits to date:
Is the employee still being treated for this injury/illness? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
If Yes, name and address of treating doctor(s):
To your knowledge, did the employee have another work-related injury to the same body part or a similar illness while working for you? Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, name of doctor(s) who treated the previous injuries/illnesses (if known):
Did you provide any medical care? Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, please describe what and when:

COMMENTS:

If Non-Work Related or You Are Disputing this claim, then NYS Disability Insurance Information Required:

NYS DB Company: _____
 Address: _____
 City, State, Zip: _____
 Policy#: _____

Report prepared by: _____ Date: _____

Email address: _____
 (Please print legibly)