# EMPLOYER'S REPORT OF WORK-RELATED INJURY/ILLNESS

C-2

*State of New York - Workers' Compensation Board*

If one of your employees has a work-related injury or illness, you must complete and file this form within 10 days of the injury/illness or be subject to a penalty. For additional information on filing this form please refer to Workers' Compensation Law Section 110 at the end of this form. Type or print neatly.

WCB Case Number (if you know it): _____ Date of Injury/illness: ____/____/____

Carrier Case Number (if you know it): _____ Date of this Report: ____/____/____

## A. EMPLOYER INFORMATION

1. Employer: _____ 2. Employer FEIN: _____

3. Mailing Address: _____

4. Location Address (if different): _____

5. Phone Number: (____)_____ 6. Nature of Business or Industry Code: _____

7. OSHA Case Number (if known): _____ 8. NY UI Employer Reg Number: _____

## B. INSURANCE CARRIER / SELF-INSURED EMPLOYER

*If individually self-insured, enter your Board W Number and skip to Section C.*

1.Board W Number: W _____ 2. Carrier/Group Name: _____

3. Policy Number: _____ Policy Period: From: ____/____/____ To: ____/____/____

4. If Carrier Unknown, Insurance Agent Name: _____ 5. Phone Number: (____)_____

## C. EMPLOYEE'S PERSONAL INFORMATION

1. Name: _____ 2. Date of Birth: ____/____/____
First MI Last

3. Mailing Address: _____

4. Social Security Number: _____ 5. Contact Phone Number:(____)_____ 6. Gender: ☐ Male ☐ Female

## D. EMPLOYEE'S INJURY OR ILLNESS

1. Time of day employee began work on date of injury: _____ ☐ AM ☐ PM 2. Time of injury: _____ ☐ AM ☐ PM

3. Has the employee given you notice of injury/illness? ☐ Yes ☐ No

If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice provided: ____/____/____

***If available, attach a copy of the employee's written notice and medical notes, and the employer's incident report.***

4. Have you given the employee a Claimant Information Packet? ☐ Yes ☐ No If yes, give date: ____/____/____

5. Where did the injury/illness happen (e.g., 1 Main St., Pottersville, at the front door): _____

_____

6. Was this location where the employee normally worked? ☐ Yes ☐ No If no, why was the employee there? _____

_____

7. Employee's supervisor: _____ 8. Did supervisor see injury happen? ☐ Yes ☐ No ☐ Unknown

9. Did anyone else see the injury happen? ☐ Yes ☐ No ☐ Unknown If yes, give name(s): _____

_____

10. What was the employee doing when he/she was injured or became ill? (e.g., unloading a truck, stocking a shelf, typing annual report)

_____

_____

EMPLOYEE'S NAME: _____ DATE OF INJURY/ILLNESS: ____/____/____
First MI Last

## G. EMPLOYEE'S WORK INFORMATION on the date of the injury or illness

1. Date the employee was hired: ____/____/____
2. What was the employee's job title? _____
3. What types of activities did the employee normally perform at work? (Attach job description if available.) _____

_____

_____

## H. EMPLOYEE'S PAYROLL INFORMATION on the date of the injury or illness

1. Employee's gross pay in an average week was: $ _____
2. Did the employee receive lodging or tips in addition to pay? ☐ Yes ☐ No If yes, describe: _____

_____

3. Employee's job was (check one): ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____
4. Which days of the week did the employee usually work? ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.
5. Was the employee paid for a full day on the day of the injury/illness? ☐ Yes ☐ No
6. Did you continue to pay the employee after the injury/illness (e.g., sick leave, vacation, disability, regular salary)? ☐ Yes ☐ No

## I. ADDITIONAL INFORMATION

_____

_____

_____

_____

_____

**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: (____)_____

*If prepared by a Third Party on Behalf of the Employer:*

Signature of Person Preparing Form: _____ Date: ____/____/____

Print Name: _____ Title: _____ Phone Number: (____)_____

Company Name and Address: _____

Name & Phone Number of Person Who Provided Information Necessary to Prepare This Form: _____

**Reports should be filed by sending directly to the appropriate WCB district office (DO) at the address below with a copy sent to the insurance carrier:**

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 NY13901 866-802-3604 (for accidents in the following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)
Buffalo DO - Statler Towers, 107 Delaware Avenue, Buffalo NY 14202 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 Poughkeepsie 866-746-0552 (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)

# 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).