Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

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

3. Mailing address: _____ (Number and Street/PO Box / City / State / Zip Code)

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

7. Do you speak English? ☐ Yes ☐ No If no, what language do you speak? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: _____/_____/_____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: _____/_____/_____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____ DATE OF INJURY/ILLNESS: _____/_____/_____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: _____/_____/_____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? _____/_____/_____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? _____/_____/_____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? _____/_____/_____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   _____ Phone Number: (_____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: _____
   _____ Phone Number: (_____)_____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   _____
   _____
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

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.

Employee's Signature: _____ Print Name: _____ Date: _____/_____/_____

On behalf of Employee: _____ Print Name: _____ Date: _____/_____/_____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: _____/_____/_____

Print Name: _____ Title: _____

ID No., if any: **R** _____ If Licensed Representative, License No.: _____ Expiration Date: _____/_____/_____