First Report of InjuryFiling 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 ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other ☐
Work Week (days worked): M ☐ T☐ W ☐ TH☐ F☐ Sat ☐ Sun ☐
Was the employee paid for a full day on the day of the injury/illness? Yes ☐ No ☐
Did the employee receive lodging or tips in addition to pay Yes ☐ No ☐ If yes, describe:
Last date worked: / / Last date paid: / / In Full? Yes ☐ No ☐
Did you continue to pay the employee after the injury/illness (e.g. sick leave, vacation, disability, regular salary)? Yes ☐ No ☐
If Yes, is reimbursement requested? Yes ☐ No ☐

Accident Information:

Date of Accident: / / Time of Accident: AM ☐ PM ☐
Time employee began work on Date of accident: AM ☐ PM ☐
Has the employee given you notice of injury/illness? Yes ☐ No ☐
Date notice provided __/__/__ If Yes, Name & Title of person to whom accident was reported: Oral ☐ Written ☐
His or Her Phone#
Address where Accident occurred: Assured address? Yes ☐ No ☐
If No, please give address where accident occurred:
Was this location where the employee normally worked? Yes ☐ No ☐
If No, why was employee there?
Did Supervisor see injury happen? Yes ☐ No ☐ Unknown ☐
Did anyone else see injury happen? Yes ☐ No ☐ Unknown ☐
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 ☐ No ☐
If Yes, what was it?
Was the injury the result of the use or operation of a licensed motor vehicle? Yes ☐ No ☐
If Yes: Employee's vehicle ☐ Employer's vehicle ☐ Another vehicle ☐

License plate number (if known)
Auto Insurance information:
Did the injury/illness result in the employee's death? Yes ☐ No ☐ If Yes, what was the date of death? ____/____/____
Have you given the employee a claimant information packet? Yes ☐ No ☐ 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 ☐ No ☐
Is claimant/employee back to work? Yes ☐ No ☐ Date of return to work: ____/____/____
Full Pay? Yes ☐ No ☐ If No, average gross earnings?

MEDICAL TREATMENT INFORMATION:

Date of employee's first medical treatment: ____/____/____ None received ☐ Unknown ☐
Where did the employee receive first medical treatment for this injury/illness? Onsite ☐ Doctor's office ☐ Emergency Room ☐Clinic/Hospital/Urgent Care ☐ Hospital stay over 24hours ☐ Unknown ☐
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 ☐ No ☐ Unknown ☐
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 ☐ No ☐
If Yes, name of doctor(s) who treated the previous injuries/illnesses (if known):
Did you provide any medical care? Yes ☐ No ☐
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)