

NOTICE: Department must call in employee injury within 24 hours of injury. (1-888-682-4301)
Employee & Supervisor: Complete this form upon occurrence of injury or recurrence of injury on duty and make three (3) photocopies.
Supervisor: Complete the Department Section on front side of form, Employee's Section if applicable, and Investigation Form on reverse side. FAX BOTH SIDES OF FORM TO Workers' Compensation Unit 718-694-3281/3807 and to System Safety (646) 252-5793. Send original within two business days to Workers' Comp., 130 Livingston Street, 10th floor. Send copy to the Dept. Injury Reporting Unit; and keep 1 copy.
\* Employee: Complete Employee Section and Differential Application on front side of this report and keep 1 copy.

PLEASE PRINT - FULLY ANSWER ALL QUESTIONS AND BOTH SIDES OF FORM
MTA-NYCT [ ] MABSTOA [ ] UNION AFFILIATION: \_\_\_\_\_

EMPLOYEE'S SECTION (If employee is not available, Supervisor must fill out and sign form)

Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Pass/Payroll #: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_
Home Address (& Apt. #): \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Sex (M/F) \_\_\_\_\_
Job Title \_\_\_\_\_ Title Code \_\_\_\_\_ Date of Hire \_\_\_/\_\_\_/\_\_\_
Dept./Division: \_\_\_\_\_ Resp. Ctr. #: \_\_\_\_\_ Notified: \_\_\_/\_\_\_/\_\_\_ Date Supervisor \_\_\_\_\_ Hrs Worked \_\_\_\_\_ Hrs Worked \_\_\_\_\_
Pre-Injury Work Status: \_\_\_\_\_ Recurrence of Prior Injury? \_\_\_\_\_ Day of Inj: \_\_\_\_\_ Prior 7 Days: \_\_\_\_\_
Full: \_\_\_ Rest: \_\_\_ No Work: \_\_\_ Y: \_\_\_ N: \_\_\_ Unknown: \_\_\_ Date of Prior Injury: \_\_\_\_\_ RDOs \_\_\_\_\_
Hrs. of Duty: \_\_\_\_\_ Wages/Hr: \_\_\_\_\_ Work Hrs/Day: \_\_\_\_\_ Work Hrs/Week: \_\_\_\_\_ Scheduled Lunch: \_\_\_\_\_

DESCRIBE INJURY

Inj. Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_ AM PM (circle one) Date of Death (if applicable): \_\_\_/\_\_\_/\_\_\_
Location/Facility/Station/Building/Depot: \_\_\_\_\_ Area/Booth/Vehicle #/Track \_\_\_\_\_ County \_\_\_\_\_
What were you doing when injured or when injury recurred? \_\_\_\_\_

How did injury/exposure occur? \_\_\_\_\_
What object or substance directly harmed the employee? \_\_\_\_\_
Why did injury occur? \_\_\_\_\_
Nature of injury: (type of injury AND part of body) \_\_\_\_\_
Medical Treatment Requested? Y: \_\_\_ N: \_\_\_ Received Workers' Comp. Statement of Rights? Y: \_\_\_ N: \_\_\_
Received Injury on Duty Instruction Sheet? Y: \_\_\_ N: \_\_\_

\* Please be advised that in the event of a lost time injury greater than 30 days, (greater than 15 days for DOB employees), lost time relating to the on-the-job injury will be designated as leave usage under the Family Medical Leave Act (FMLA) if you are otherwise eligible. This notice does not constitute a waiver of any right that the Transit Authority has to controvert the claimed on-the-job injury.

Employee Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Supv. Signature: \_\_\_\_\_
(if employee fails to sign)

DIFFERENTIAL APPLICATION

Employee must sign Differential Application to begin processing. Signature does not denote agreement with Supervisor's Report nor Workers' Compensation determinations of eligibility.
I understand that, in making this application for Differential Benefit, I have agreed that the Authority may seek to recoup the value of Differential Benefits paid from any judgment or settlement of an action against third parties I may institute as a result of this Injury.
I hereby apply for payment of differential
Employee's Name (please print) \_\_\_\_\_ Employee's Signature: \_\_\_\_\_ Date \_\_\_\_\_

DEPARTMENT SECTION

TELEPHONIC CONTROL # \_\_\_\_\_

DATE REPORT TO MAC FOR DRUG/ALCOHOL TESTING: \_\_\_/\_\_\_/\_\_\_
Was injury observed?: Y: \_\_\_ N: \_\_\_ RULE COMPLIANCE: At time of injury was employee:
If yes, was it job related?: Y: \_\_\_ N: \_\_\_ Unk: \_\_\_ Performing assigned duties? Y: \_\_\_ N: \_\_\_
Date Stopped work: \_\_\_/\_\_\_/\_\_\_
Has injured returned to work? Y: \_\_\_ N: \_\_\_ Return to work date: \_\_\_/\_\_\_/\_\_\_

WAIVER & ELECTION REQUESTED: Y: \_\_\_ N: \_\_\_ If yes, employee must complete Waiver & Election Form.

Supervisor Name: \_\_\_\_\_ Supv. Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_ Phone \_\_\_\_\_
Effective 3/2009

# ON THE JOB INJURY INVESTIGATION FORM

RESPONSE INJURED EMPLOYEE NAME: \_\_\_\_\_ PASS NUMBER: \_\_\_\_\_

## INJURY INFORMATION

FIRST AID RENDERED: yes no Detail: \_\_\_\_\_ FIRST AT THE INJURY SCENE: \_\_\_\_\_  
AREA SECURED/IMMEDIATE HAZARD ELIMINATED: yes Time: \_\_\_\_\_ no Why: \_\_\_\_\_  
IF TREATMENT GIVEN AWAY FROM WORKSITE, WHERE WAS IT GIVEN? FACILITY: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
TREATED IN E/R?: es no HOSPITALIZED OVERNIGHT?: yes no  
NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL: \_\_\_\_\_

## FACT-FINDING

### WITNESS INFORMATION

INJURED EMPLOYEE INTERVIEWED: yes Date: \_\_\_\_\_ no Why: \_\_\_\_\_  
NAME, PASS NUMBER, JOB TITLE OF ALL WITNESSES: \_\_\_\_\_  
DATE INTERVIEWED: \_\_\_\_\_  
DATE INTERVIEWED: \_\_\_\_\_

### INJURY SCENE INFORMATION

LOCATION DETAIL: Train – work/passenger/other \_\_\_\_\_ # \_\_\_\_\_ Yard \_\_\_\_\_ Tower \_\_\_\_\_ Track # \_\_\_\_\_ Station \_\_\_\_\_ Shop \_\_\_\_\_  
Bus – passenger/other \_\_\_\_\_ Bus # \_\_\_\_\_ Depot \_\_\_\_\_ Storeroom # \_\_\_\_\_ Street \_\_\_\_\_ Vehicle # \_\_\_\_\_  
Other \_\_\_\_\_  
PHOTOGRAPH TAKEN: yes no Why? \_\_\_\_\_ SKETCH MADE: yes no Why? \_\_\_\_\_  
DETAIL OF INJURY SCENE:  
LIGHTING CONDITIONS: good poor other \_\_\_\_\_ WEATHER: clear cloudy rain snow other \_\_\_\_\_  
STRUCTURAL ELEMENTS (hole in floor, chipped stair, missing handrail, etc.) good poor Detail: \_\_\_\_\_  
HOUSEKEEPING: good poor Detail: \_\_\_\_\_ OTHER: \_\_\_\_\_  
EQUIPMENT/MACHINE/TOOL INVOLVED  
NAME (include identification number if applicable) \_\_\_\_\_ CONDITION: good poor OTHER: \_\_\_\_\_

## ANALYSIS

### PEOPLE/PROCEDURES

POLICY/PROCEDURE APPLICABLE: yes no FOLLOWED: yes no  
TRAINING REQUIRED: yes no COMPLETED: yes no  
PERSONAL PROTECTIVE EQUIPMENT REQUIRED: yes no IN USE: yes no  
CONDITION OF PPE: good poor Detail \_\_\_\_\_ OTHER: \_\_\_\_\_

### EQUIPMENT

FAILURE: yes no CAUSE OF FAILURE: IMPROPER OPERATION: \_\_\_\_\_ LACK OF MAINTENANCE: \_\_\_\_\_ OTHER: \_\_\_\_\_  
MACHINE/TOOL USED CORRECTLY: yes no INSPECTION REQUIRED: yes no LAST INSPECTION: \_\_\_\_\_  
SAFEGUARDS REQUIRED: yes no IN PLACE: yes no IN USE: yes no

### MATERIAL

EXPOSED TO: \_\_\_\_\_ CONTACT WITH \_\_\_\_\_ USED CORRECTLY: yes no  
SAFEGUARDS REQUIRED: yes no IN PLACE: yes no IN USE: yes no

### ENVIRONMENT

HEAT RELATED: yes no COLD RELATED: yes no OTHER: yes no \_\_\_\_\_  
SAFEGUARDS REQUIRED: yes no IN PLACE: yes no IN USE: yes no

### MISCELLANEOUS CONTRIBUTING FACTORS

OTHER EMPLOYEES: \_\_\_\_\_ INJURED EMPLOYEE DISTRACTED: \_\_\_\_\_ DRUG/ALCOHOL: \_\_\_\_\_ OTHER: \_\_\_\_\_

### ROOT CAUSE OF INJURY (Why did injury/exposure occur?)

## RECOMMENDATIONS

### ACTION PLAN TO PREVENT RECURRENCE (What can be done to prevent another similar injury?)

ACTION PLAN IMPLEMENTED: yes no DATE: \_\_\_\_\_ COMPLETED: yes no DATE: \_\_\_\_\_

### COMMUNICATED RESULTS AND RECOMMENDATIONS

EMPLOYEES: yes no DATE: \_\_\_\_\_ OTHER DIVISIONS: yes no DATE: \_\_\_\_\_

ILLNESS CASES ONLY: Check this box →  ← if the employee independently and voluntarily requests that his or her name not be entered of the log. If checked, treat as a privacy concern case.

INVESTIGATOR NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ PASS # \_\_\_\_\_  
(Please print)

LOCATION MANAGER: NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(Please print)

PASS # \_\_\_\_\_ PHONE # \_\_\_\_\_

REV: 5/25/07

REQUEST FOR PAYMENT WHILE ABSENT DUE TO SERVICE CONNECTED DISABILITY

I, \_\_\_\_\_, request eight hours pay for each work day I am absent due to a service connected injury. Such payment shall begin with the first work day of absence and will be charged against my accrued sick leave and/or vacation time (check one or both) and will continue if eligible for maximum 20 days until I return to work, whichever comes first. I understand that, in making this request, I am waiving any rights which I might otherwise have to use such accrued time for other reasons. I understand that I must provide medical documentation from my treatment provider pursuant to the Workers' Compensation Law and, if I do not provide such information and do not certify my absence through providing a sick leave application/doctor's certification, benefits paid to me through this waiver and election will be recouped.

Date \_\_\_\_\_ Signed \_\_\_\_\_  
Pass \_\_\_\_\_ Title \_\_\_\_\_  
Department \_\_\_\_\_  
Date of Accident \_\_\_\_\_  
Date of Initial Absence \_\_\_\_\_

To be completed by Department/Division:

The Workers Compensation Division has indicated that this case is

\* Controverted \* Non-Controverted per \_\_\_\_\_ (name) on \_\_\_\_\_ (date).

Sick Leave Balance \_\_\_\_\_ Annual Leave Balance \_\_\_\_\_

Payroll payment commenced \_\_\_\_\_

Department will submit a copy of this form to Timekeeping, Payroll and the Workers' Compensation Division immediately upon completion of this section. If the \* information is not available complete the remaining portion and transmit as indicated.

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_

Upon return to duty or exhaustion of leave credits, department shall complete and submit a copy of this form to the Workers Compensation Division:

Date returned to duty \_\_\_\_\_ Date leave credits exhausted \_\_\_\_\_

Leave Used: \_\_\_\_\_ Sick Leave Days \_\_\_\_\_ Vacation Days (insert number of days)

Amount paid: \$ \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_

Workers Compensation Division shall complete and send to employee's department and Payroll:

Workers Compensation paid at \$ \_\_\_\_\_ /week for \_\_\_\_\_ to \_\_\_\_\_.

Workers Compensation paid at \$ \_\_\_\_\_ /week for \_\_\_\_\_ to \_\_\_\_\_.

Differential pay should be granted for \_\_\_\_\_ to \_\_\_\_\_.

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_

Department to complete and file:

Based on above award(s), employee is entitled to be credited with

\_\_\_\_\_ sick leave and/or \_\_\_\_\_ vacation days.

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_

**NEW YORK CITY TRANSIT  
ON THE JOB INJURY MANAGEMENT FOLLOW-UP FORM**

Employee Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Pass Number: \_\_\_\_\_  
Department/Division: \_\_\_\_\_  
Division RC: \_\_\_\_\_  
Work Location: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

Manager Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Pass Number: \_\_\_\_\_  
Department/Division: \_\_\_\_\_

Date of injury: \_\_\_\_\_  
Description of injury \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Action Taken:**

Emergency Room  
Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Telephone: \_\_\_\_\_  
Physician: \_\_\_\_\_

Personal Physician  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Telephone: \_\_\_\_\_

Medical Assessment Center (MAC), or  
 Independent Medical Examiner (IME)  
Location: \_\_\_\_\_  
Physician: \_\_\_\_\_  
Telephone: \_\_\_\_\_

Other, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employee condition: \_\_\_\_\_  
\_\_\_\_\_

Non- work related condition identified, explain: \_\_\_\_\_  
\_\_\_\_\_

Can employee work the following day?  Yes  No  
If No, when can employee return to work? \_\_\_\_\_  
If return date is unknown, when is employee's next evaluation? \_\_\_\_\_

Contact day of employee: \_\_\_\_\_  
 Full duty: perform routine tasks  
 Restricted, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Restricted work available  
 Restricted work unavailable  
 Return to full work Date: \_\_\_\_\_  
 Employee failed to report to full work Date: \_\_\_\_\_  
 Employee failed to keep MAC/IME visit Date: \_\_\_\_\_

Manager's Signature \_\_\_\_\_

Date \_\_\_\_\_

WORKERS' COMPENSATION

INJURY ON DUTY MEDICAL FORM

This form is not a substitute for a C-4/C48 Form

TO BE COMPLETED BY EMPLOYEE AND TREATING PHYSICIAN AND SUBMITTED TO YOUR DEPARTMENT FOR FORWARDING TO THE WORKERS' COMPENSATION DIVISION

PLEASE PRINT

EMPLOYEE NAME: DATE OF EXAMINATION:

DATE OF ACCIDENT PASS # SOCIAL SECURITY #

HEALTH CARE PROVIDERS NAME: SPECIALTY:

HEALTH CARE PROVIDER'S ADDRESS AND TELEPHONE #

The employee must return to his/her department with this form immediately after the visit to treating physician.

TO BE COMPLETED BY EMPLOYEE'S PHYSICIAN

PHYSICIAN DIAGNOSIS/OBJECTIVE FINDINGS/REQUEST FOR TREATMENT:

DRUGS TAKEN: NONE NAME OF DRUG(S) IMPACTS FUNCTIONAL ABILITIES YES NO

EXAM DATE NEXT EXAM DATE TIME

FULL WORK NO WORK RESTRICTED WORK (AS INDICATED BELOW)

IS CURRENT DISABILITY DIRECTLY RELATED TO ACCIDENT? YES NO UNKNOWN RESOLVED PERMANENT CONTINUED TEMPORARY NO DISABILITY

DEGREE OF RESTRICTED DISABILITY MILD MODERATE MARKED TOTAL

RESTRICTIONS (INDICATE APPLICABLE RESTRICTIONS)

Table with columns for weight limits (-0, 10, 20, 50, OVER 50) and activities (LIFTING, PUSHING, PULLING, TWISTING, CLIMBING, BENDING, KNEELING, SITTING, WALKING, CANNOT, WORK OUTDOORS, etc.)

COMMENT ON RESTRICTIONS BELOW (IF NECESSARY)

PHYSICIAN NAME PHYSICIAN SIGNATURE WCB RATING

PHYSICIAN FAX NUMBER PHYSICIAN ADDRESS PHYSICIAN TELEPHONE#

FOR AGENCY USE ONLY

DEPARTMENT: WHEN EMPLOYEE IS GIVEN RESTRICTED DUTY, COMPLETE AND FAX TO (718-694-3100 OR 718-694-1610)

WORK AVAILABLE START DATE WORK NOT AVAILABLE (EMPLOYEE SENT HOME)

SUPERVISOR NAME SUPERVISOR SIGNATURE PASS PHONE#

DEPARTMENT NAME RCN DATE

\*REMINDER- EMPLOYEES ABSENT 21 DAYS OR MORE A DRUG TEST IS REQUIRED.

Reissued 6/07/06

Effective 3/2009

**WORKERS' COMPENSATION INJURY/ILLNESS ON DUTY  
INSTRUCTION SHEET**

To avoid **DELAY** or **DENIAL** of **COMPENSATION, DIFFERENTIAL**  
or **ASSAULT** pay, the following procedures **MUST** be followed  
when claiming a job related injury.

1. **COMPLETE THE INJURY ON DUTY REPORT WITH DIFFERENTIAL APPLICATION IMMEDIATELY**  
Late filing may result in a DELAY in COMPENSATION PAYMENTS AND DENIAL of DIFFERENTIAL PAY.
2. **READ THOROUGHLY STATEMENT OF RIGHTS** published by the New York State Workers' Compensation Board.
3. **REQUEST FOR PAYMENT WHILE ABSENT DUE TO CLAIMED SERVICE-CONNECTED DISABILITY**  
If provided for in the relevant collective bargaining agreement, NYC Transit Authority employees, who are not receiving workers' compensation payments, may request to use his/her sick leave and/or vacation time beginning with the 1<sup>st</sup> day of absence by submitting the appropriate form. You should contact your supervisor and/or union representative if you have any questions about this process.
4. **YOUR OWN PRIVATE PHYSICIAN'S CARE:** Your physician must file a **C-4 OR C-48** form with the Authority's Workers' Compensation Division and the Workers' Compensation Board as soon as possible. Absent receipt of the C-4 or requisite, acceptable medical lines (these must include diagnosis, medical findings, not solely conclusions, and a work status – see form supplied by Supervisor) from your treating physician by the Workers' Compensation Division, your workers' compensation\* and differential benefits will not commence. Failure to submit medical documentation may result in your being considered absent without leave. Additional medical lines may be requested by the Workers' Compensation Division. All physician medical invoices are to be mailed to the Workers' Compensation address listed below.
5. **INDEPENDENT MEDICAL EXAMINATION (IME)**
  - **REPORT TO AUTHORITY IME PHYSICIAN AS DIRECTED BY** the mail notice you receive (by express and/or regular mail and possibly by hand). The notice will be received at least seven business days (excluding Saturday and Sunday) before the scheduled examination.
  - **IF YOU RETURN TO WORK PRIOR TO YOUR IME APPOINTMENT** you must report to the Safety Unit at 130 Livingston Street, 6<sup>th</sup> floor on your next scheduled work day, Sunday through Saturday, between 0800 -1600 hours, **IN FULL UNIFORM**. You must bring with you acceptable medical lines and a copy of your completed On the Job Injury form. The Safety Unit will inform you, based on the determination made by the Workers' Compensation Division if you must keep your scheduled IME appointment.
  - **A FAILURE TO REPORT TO THE MEDICAL IME EVALUATION** may result in a denial of workers' compensation\* or differential benefits. If you have returned to work prior to the scheduled IME examination, you should check to determine whether the examination is still required.
  - **IF UNABLE TO TRAVEL TO THE IME EVALUATION:** You must give your department and the Workers' Compensation Division at least two business days advance notice if you cannot go to the consultant physician on the scheduled date. If unable to attend the Medical IME Evaluation, you must call/fax the Medical Consultant Unit listed below for notification. You will be required to prove your inability to attend. Ask your physician to provide his/her written opinion of your inability to travel. Absent such proof, your differential benefits may be jeopardized and you may be considered AWOL. If requested by the employee, the Authority may, based upon the circumstances, arrange for a home or hospital visit for evaluation of your medical condition.

- **OBTAIN WORK STATUS FROM MEDICAL IME AND RETURN TO YOUR DEPARTMENT:** The IME Physician will give you a Medical IME Evaluation Form which will indicate your work status - Full Work, Restricted Duty or No Work. Unless you receive directions otherwise from your department, after you receive the Medical IME Evaluation Form return to ***Employee Availability, 130 Livingston Street, 6<sup>th</sup> floor, Monday through Friday***, the Form. Your department will determine whether work is available within the restrictions indicated by the Independent Medical Examination.

***\* Subject to review by the Workers' Compensation Board.***

- **IF YOU DISAGREE WITH THE WORK STATUS DETERMINATION:** Contact your Department for instructions. If your physician's opinion regarding your work status differs from the Authority's IME physician, medical evidence (with objective findings) should be submitted in writing for review to the Injury Reporting Unit of your department and the Workers' Compensation Division at the address stated below. If you dispute a full or restricted work status give by the IME and do not return to work, you may be denied workers compensation benefits and or differential benefits. If you are uncertain about how to proceed you are to contact your supervisor and/or Union Representative for clarification.
- **A COPY OF THE IME/MEDICAL REPORT** will be forwarded to you.
- **RE-EXAMINATIONS:** You must continue to report to the Authority's IME physician as noticed in subsequent mailed notification, as well as by hand delivery at the current medical examination. You are required to bring current reports from your doctor concerning your medical status.

**KEEP IN CONTACT WITH YOUR DEPARTMENT**

---

**	Workers Compensation Division	MABSTOA TA Letter A - K TA Letter L - Z SIRTOA	(718) 694-3820 (718) 694-4860 (718) 694-4843 (718) 694-3820
----	----------------------------------	---	--

**Address: 130 Livingston St., 10th Floor  
Brooklyn, New York 11201**

**For questions related to medical consultant evaluations and/or medical documentation please contact the Medical Consultant Unit:**

Phone #s:	(718) 694-3811 694-1870 694-3278
Fax #s:	(718) 694-3100 694-1610

**\*\* Employee should select telephone number that corresponds to initial of last name.**

## STATEMENT OF RIGHTS

### TO ALL WORKERS WHO ARE INJURED WHILE WORKING OR WHO SUFFER FROM AN OCCUPATIONAL DISEASE

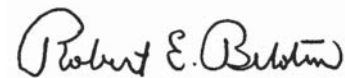
#### YOU MAY BE ENTITLED TO WORKERS' COMPENSATION BENEFITS

1. You should file a claim for benefits within two years of the date you are injured, unless your injury is very minor, requiring no medical treatment and causing no lost time from work. If you do not file within two years your right to benefits may be lost. Obtain and file a claim form (Form C-3, or VF-3 for volunteer firefighters, or VAW-3 for volunteer ambulance workers) with the nearest Workers' Compensation Board office (see addresses below).
2. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work. (In volunteer firefighters' and volunteer ambulance workers' cases, compensation for lost time or loss of earning capacity may be payable from date of injury.)
3. You are entitled to obtain any necessary medical treatment related to your injury and you should do so immediately.
4. For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Board authorized and who is accepting workers' compensation patients. If, however, your employer is involved in a certified preferred provider organization (PPO) arrangement, you must obtain initial treatment for any workers' compensation injury or illness from the preferred provider organization. Employers participating in this statutory program are required to provide their employees with written notification describing their employees' rights and obligations under the program.
5. You should inform your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and your employer's insurance company, which is indicated at the bottom of this form.
6. You should not pay any medical providers directly for treatment of your work-related injury or illness. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
7. The employer is liable for the replacement or repair of an employee's prosthesis (e.g., artificial members, false teeth, eyeglasses), which has been lost or damaged in the course of employment, whether or not there was bodily injury to the employee. You are also entitled to be reimbursed for drugs, crutches or any apparatus properly prescribed by your doctor, and transportation and other necessary expenses going to and from your doctor's office or hospital. (You should get receipts for all such expenses.)
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire an attorney or licensed representative, you should not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. Lost time and medical benefits are payable directly without a formal direction from the Board, unless your claim is disputed. If your claim is disputed on the grounds that your injury is not work-related or did not arise in the line of volunteer firefighter or ambulance worker duties, then you may qualify for disability benefits for non-work injuries. For more information on entitlement to disability benefits, contact the Workers' Compensation Board office nearest you.
10. You should go back to work as soon as you are able; compensation is never as high as your wage. If you need help returning to work, or with family or financial problems because of your injury, you should contact the nearest Board office and ask for a rehabilitation counselor or social worker.
11. Your employer may not ask you to waive your right to compensation nor may your employer deduct any money from your pay to contribute to the payment of workers' compensation insurance premiums. Further, you cannot be discharged or discriminated against because you filed a claim for workers' compensation benefits.

**IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A JOB-RELATED INJURY OR DISEASE, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.**

This information is a simplified presentation of your rights under the Workers' Compensation Law. It is provided, as required by Section 110 of the Workers' Compensation Law, by your employer's insurance carrier:

MTA-NYC Transit Workers Compensation Dept.  
130 Livingston Street, 10th Floor  
Brooklyn, New York 11201 718-694-4851



ROBERT E. BELOTEN  
CHAIR

#### DOWNSTATE CENTRALIZED MAILING

(for New York City, Hempstead, Hauppauge & Peekskill Districts)  
PO Box 5205 Binghamton, NY 13902-5205

NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552

100 Broadway State Office Building

Menands 44 Hawley Street 369 Franklin Street 130 Main Street W. 935 James St.  
ALBANY 12241 BINGHAMTON 13901 BUFFALO 14202 ROCHESTER 14614 SYRACUSE 13203  
(866) 750-5157 (866) 802-3604 (866) 211-0645 (866) 211-0644 (866) 802-3730

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.



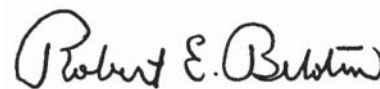
**A TODO EMPLEADO LESIONADO EN EL TRABAJO O QUE SUFRA DE ENFERMEDAD OCUPACIONAL:  
USTED PUEDE TENER DERECHO A BENEFICIOS DE COMPENSACION OBRERA**

1. Usted deberá presentar una reclamación de beneficios dentro del término de dos años del día en que fue lesionado, a menos que la lesión sea tan pequeña que no requiera tratamiento médico y que no cause interrupción en su jornada de trabajo. Si no radica dentro del término de dos años, puede perder sus derechos a beneficios. Consiga y radique una forma de reclamación (Forma C-3, o VF-3 para bomberos voluntarios, o VAW-3 para empleados voluntarios de ambulancias) en la oficina más cercana de la Junta de Compensación Obrera (direcciones más abajo).
2. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo. (Bomberos voluntarios y Trabajadores de Ambulancia Voluntarios pueden ser compensados desde el mismo día de su lesión.)
3. Usted tiene derecho a recibir tratamiento médico relacionado con su lesión y debe obtenerlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropráctico ó psicólogo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en esta programa establecida por ley están obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañía de seguros de su patrono, que se indica al final de esta forma.
6. No pague a ningún proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
7. El patrono es responsable de la sustitución y reparación de aquellos implementos médicos que han sido perdidos o se han deteriorado como consecuencia del empleo, sin que importe el que el empleado haya onosufrido lesión (Ej. miembros artificiales, dentadura postiza, espejuelos). Usted también tiene derecho a ser reembolsado por medicinas, muletas, o cualquier otro implemento debidamente recetado por su médico y por transportación u otro gasto necesario para ir al médico ó al hospital. (Obtenga recibos para justificar gastos.)
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios serán determinados por la Junta y descontados de sus beneficios.
9. La compensación se paga inmediatamente, sin esperar por la adjudicación del caso, excepto cuando la reclamación es cuestionada. Si la reclamación es cuestionada en base a que la incapacidad no fue causada por un accidente relacionado con su trabajo ó por una enfermedad ocupacional ó por una lesión en el cumplimiento de su deber como bombero voluntario ó como miembro voluntario del cuerpo de ambulancia, usted puede tener derecho a recibir beneficios por incapacidad (para lesiones fuera del trabajo). Si su reclamación es cuestionada y no está recibiendo beneficios por incapacidad, comuníquese con cualquier oficina de la Junta.
10. Regrese a su trabajo tan pronto pueda. La compensación nunca es tan alta como su sueldo. Si necesita ayuda para regresar al trabajo ó para resolver problemas financieros ó personales por causa de la lesión sufrida, comuníquese con la oficina más cercana de la Junta y solicite hablar con un trabajador social o con un consejero de rehabilitación.
11. Su patrono no puede solicitar que usted le releve de su derecho a compensación, ni puede descontar cantidad alguna de su paga para contribuir al pago de las primas del seguro. Usted no podrá ser despedido ni penalizado por radicar una reclamación en la Junta.

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLAMACIÓN O NECESITA AYUDA PARA LLENARLO Ó TIENE DUDAS SOBRE CUALQUIER SITUACIÓN RELACIONADA CON UNA LESIÓN O ENFERMEDAD COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA.

Este resumen es una compilación de los puntos más importantes de sus derechos bajo la ley de compensación obrera. La sección 110 de la ley requiere de su patrono ofrecerle esta información.

MTA-NYC Transit Workers Compensation Dept.  
130 Livingston Street, 10th floor  
Brooklyn, New York 11201 718-694-4851



ROBERT E. BELOTEN  
PRESIDENTE

<b>DOWNSTATE CENTRALIZED MAILING</b> (for New York City, Hempstead, Hauppauge & Peekskill Districts) PO Box 5205 Binghamton, NY 13902-5205 NYC (800)877-1373/ Hemp. (866)805-3630/ Haup. (866)681-5354/ Peek. (866)746-0552	100 Broadway Menands ALBANY 12241 (866) 750-5157	State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604	369 Franklin Street BUFFALO 14202 (866) 211-0645	130 Main Street W. ROCHESTER 14614 (866) 211-0644	935 James St. SYRACUSE 13203 (866) 802-3730
--	---	---	--	---	---

---

# **INJURED ON THE JOB?**

**An Employee's Guide to  
Workers' Compensation in  
New York State**



**New York State Workers' Compensation Board**

---

## Privacy Statement

All documents the Workers' Compensation Board has about your case are private. Under workers' compensation law, only the parties to your claim may receive information from your case file. Beyond you and your attorney or representative, the parties who may see information include

- your employer and your employer's attorney
- your employer's workers' compensation insurance carrier and its attorney

That insurance carrier may share information with health care providers it hires to examine you. Your health care providers will have to share your health information with that insurer when they bill for their services.

Anyone who obtains a court order authorizing access to your claim information is also included. Your information may also be shared with government entities if they are processing a claim for benefits or investigating fraud.

No one may disclose your information to anyone who is not authorized to see it.

You may give written permission to anyone you choose to access your claim information, in two ways.

1. File an original Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records. This is available from [www.wcb.state.ny.us/content/main/forms/Forms\\_CLAIMANT.jsp](http://www.wcb.state.ny.us/content/main/forms/Forms_CLAIMANT.jsp), or by calling 1.866.750.5157.
2. File an original notarized letter or form where you authorize a particular person or entity to see your claim information.

You may submit an authorization at any time. It's always helpful to share a copy of that document with the person you authorize to see your records. Some people authorize their spouse or child to access their records when they initially file for benefits.

Prospective employers may not ask you to give them information about your workers' compensation claims before hiring you.

## Table of Contents

Privacy Statement ..... i

What is Workers' Compensation? ..... 2

How to File a Claim ..... 2

Who Is and Isn't Covered? ..... 3

A Worker's Responsibilities ..... 3

Medical Care ..... 4

Occupational Health Clinics ..... 5

Rehabilitation and Social Work ..... 6

Occupational Disease ..... 6

Wage Replacement (Cash) Benefits ..... 7

Reduced Earnings Benefits ..... 7

Disability Classifications ..... 8

Resolving Disputed Claims ..... 9

Disability Benefits During a Dispute ..... 9

Death Benefits ..... 10

Social Security Benefits ..... 10

Discrimination ..... 10

A Timeline for Your Case ..... 11

Common Questions ..... 11

Directory of WCB Board Offices ..... 13

The C-3 and C-3.3 forms follow the text of this document.

This pamphlet is a general, simplified presentation of workers' compensation provisions and procedures. It is not a substitute for the law or legal advice.

The Workers' Compensation Board does not discriminate on the basis of race, color, national origin, sex, religion, age, disability or sexual preference when providing services or in employment.

Workers' compensation fraud is a felony, punishable by fines and up to seven years imprisonment. To report fraud, call 1-888-363-6001.

## What is Workers' Compensation?

Workers' compensation is a form of insurance. Most employers must carry this insurance for workers who are injured or become ill because of their jobs. It provides for medical care, and wages you lose because your ability to work is affected. Employers pay for this insurance and may not ask you to pay anything toward the cost. The benefits are paid by an insurance carrier, or by the employer if it insures itself. Benefits are paid according to the law, and the Workers' Compensation Board ensures they are correctly provided.

The Workers' Compensation Board is a state agency that oversees how employers and insurers handle the claims of injured workers. A claim is paid if the insurer agrees the incident is work-related, or if the Board orders it. An employer or its insurer can dispute the claim. If that happens, the Board will try to resolve the dispute within 90 days. For example, the insurer may believe the incident didn't occur at work. It may not even agree that it covered your employer when you were hurt. Other issues may also arise. Whatever the reason, the Board will try to resolve it as quickly as possible.

You don't need to lose time from work to file a claim. No one needs to be found at fault for you to receive benefits. Claimants don't receive less if they were careless, nor do they receive more if the employer is at fault. However, a worker loses the right to benefits if the injury results solely from using drugs or alcohol, or from trying to injure herself or someone else.

### HOW TO FILE A CLAIM

*You must report the injury, in writing, to your employer within 30 days of the accident. **The Board must be notified of your case within two years of the accident.** You must also file a claim for compensation as soon as possible.*

*You may file Form C-3, Employee's Claim for Compensation, one of three ways.*

*1. Online, go to [www.wcb.state.ny.us/content/main/onthejob/howto.jsp](http://www.wcb.state.ny.us/content/main/onthejob/howto.jsp) to complete the form.*

*2. Complete a paper C-3 and mail it to the nearest Board office. A C-3 is in the center of this pamphlet, and Board addresses are on the back.*

*3. Call 1-866-396-8314. A Board representative will complete it with you.*

*You will be notified by mail if a hearing is necessary.*

## Who Is Covered?

- Workers in all for-profit businesses.
- County and municipal employees.
- Public school aides, including New York City aides. New York City shop teachers are covered; other New York City teachers are covered in another system.
- Employees of the state of New York, including some volunteer workers.
- Domestic workers employed 40 or more hours per week by the same employer. This includes full-time sitters, companions, and live-in maids.
- Farm workers whose employer paid \$1200 or more for farm labor in the previous calendar year.
- Anyone else the Board determines is an employee.

Religious, educational or charitable nonprofit entities may voluntarily cover their clergy and teachers. Domestic workers employed fewer than 40 hours a week and not living in the employer's residence may also be covered voluntarily by their employer. It isn't mandatory.

## Who Isn't Covered?

- Volunteers at nonprofit organizations.
- Clergy and members of religious orders who are performing religious duties.
- People working at educational, religious or charitable institutions who teach or perform nonmanual labor.
- People covered by federal workers' compensation laws. This includes postal workers, certain maritime trades, interstate railroad, and federal employees.
- Anyone doing yard work or casual chores at a one-family, owner-occupied home. (A minor handling power-driven machinery, including a power lawn mower, is covered.) There may be limited coverage under a homeowner's policy.
- Certain foreign government employees.
- New York City police officers, firefighters, teachers and sanitation workers are covered by another system. Other uniformed police and firefighters may also be excluded.
- Certain real estate salespeople, insurance agents and media sales representatives who sign contracts stating that they are independent contractors.
- Sole proprietors, partners, and certain one/two person corporations without employees. They may cover themselves.

---



---

## A Worker's Responsibilities

1. Try to return to work as soon as you're physically capable. Your employer may have transitional or light duty work for you.
  2. You're responsible for looking for work within your physical abilities. This may mean working outside your previous occupation.
  3. Respond to all inquiries and documents from the Board and the insurer in a timely manner.
  4. Advise the Board and other parties of address changes.
  5. Attend all hearings and appointments. Arrive on time.
  6. Answer questions thoroughly and honestly.
  7. Participate actively in your case. Don't let events happen around you.
  8. Understand any agreements you make.
  9. Ask questions of your representative and the Board.
- 
-

## Medical Care

A worker who is injured on the job or becomes ill from his work will have his health care for that condition paid under a workers' compensation claim. This care is covered whether or not you lose time from work. It is also paid in addition to any benefits you get for missed wages.

Health care providers must be authorized by the Board to see workers' compensation patients. The Board has lists of providers who are authorized to treat you. You can find a doctor on [www.wcb.state.ny.us/lps/HPSearch.jsp](http://www.wcb.state.ny.us/lps/HPSearch.jsp), or by calling 1-800-781-2362. You can receive care from any of these providers, or from your own doctor, if he or she is registered. The providers will send the bills directly to the insurer and the Board. **Do not pay any bills unless the Board disallows your case.** You may also receive reimbursement for travel to and from a health care provider's office.

If specific medical services are disputed, the insurer must pay any undisputed portion. It must also explain in writing why the services were not paid, and request any information needed to pay them. Your doctors may ask you to sign Form A-9. This states you'll pay the bills if the Board does not allow your claim, or if you drop your case before it's accepted.

## Preferred Provider Organizations

If the insurer has a network of providers to care for injured workers, you must use those providers. This is called a Preferred Provider Organization (PPO). The insurer must notify you of this. If you aren't satisfied with the care you receive from the PPO, you may select an authorized provider outside the PPO after 30 days of treatment.

## Diagnostic Networks

Insurers may also require you to use its network of facilities for diagnostic tests. Make sure to tell your doctors and other providers if the insurance carrier requires you to use its network for diagnostic test.

## Pharmacy Charges

You can go to any pharmacy, unless the insurer uses a network. Make sure the pharmacist knows you have a workers' compensation case, because many will bill the carrier directly, rather than you. However, the pharmacy can ask you to pay for the prescription up front. The insurer must reimburse you within 45 days. The pharmacy can only charge you the amount specified by law, so even if you pay in advance, you will be fully reimbursed. You're not responsible for a copayment.

If you must use an insurer's network pharmacy, the insurer must tell you how you should use it. Those pharmacies are paid directly. You will not be responsible for any charges.

## Exceptions

1. *Testing:* The insurer may not demand you use a network provider for a diagnostic test in a medical emergency. It may not demand you use a network that does not have a provider or facility within a *reasonable distance*, which is *one mile from your home or employment in an urban setting, and ten miles in a suburban or rural setting.*

2. *Pharmacy:* The insurer may not demand you use network pharmacies if it is not reasonably possible in a medical emergency. *You don't need to use network pharmacies if they don't offer mail order or aren't located a reasonable distance from you, either.*

## TYPES OF SERVICES COVERED

Medical  
Osteopathic  
Dental  
Podiatric  
Psychological  
(by referral)  
Chiropractic Treatment  
Surgery  
Hospital Care

Laboratory Tests  
Prescribed Drugs  
Nursing Services  
Surgical Appliances  
Prosthetic Devices

Preauthorization is sometimes required.

## Occupational Health Clinics

There are a number of occupational health clinics in New York that workers can use for diagnosis and treatment of workplace injuries and illnesses. See the list below, or visit <http://www.health.state.ny.us/environmental/workplace/clinic.htm> for more information.

### Buffalo

Union Occupational Health Center  
716-668-8800

### Rochester

Finger Lakes Occupational Health Services of Univ. of Rochester Medical Center  
585-244-4771  
800-925-8615

### Syracuse/Utica/Binghamton

Central New York Occupational Health Clinical Center of SUNY Health Science Center  
315-432-8899

### Cooperstown, Specialty Clinic

New York Center for Agricultural Medicine and Health of Bassett Hospital, Cooperstown  
800-343-7527 or 607-547-6023

### Albany/Poughkeepsie/Glens Falls

Occupational and Environmental Health Center of Eastern New York  
800-419-1230 or 518-690-4420

### Westchester

Mt. Sinai-I.J. Selikoff Center for Occupational and Environmental Medicine  
914-964-4737

### New York City

Bellevue/NYU Occupational and Environmental Medicine Clinic of Health and Hospitals Corp.  
212-562-4572

### Long Island

Long Island Occupational and Environmental Health Center of SUNY Stony Brook  
631-444-6250



## Rehabilitation and Social Work

*Rehabilitation* services help people return to work, and to lead full and active lives. Specific services are explained below.

*Medical rehabilitation* helps people reach maximum independence and functioning. It provides workers with information and helps them obtain medical care, physical accommodation or other special needs. Only a physician may recommend medical rehabilitation, so talk to your doctor. This service is arranged outside the Board.

*Vocational rehabilitation* helps people whose disability prevents them from returning to their usual job. Counselors help injured workers find employment that fits their abilities. They also help develop a plan to return to work. This may include vocational counseling and referrals for training and selective job placement.

*Social workers* assist people when family or financial problems interfere with their returning to work. Social workers help people cope with their disability and discuss their concerns about rehabilitation. They can also help workers prepare to return to work.

The Board has counselors, social workers and claims examiners who coordinate and monitor other services. If you could benefit from these services, contact the Board. The office telephone numbers are on the back cover of this pamphlet.

Your employer may have a *return to work* program that can get you back to your employer in light duty or an alternative position while you are healing.

## Occupational Disease

An occupational disease is contracted as the result of your work. It arises from a specific aspect of the work that you perform. For example, people who remove asbestos may contract asbestosis. People who work on computers may suffer carpal tunnel syndrome.

You may be disabled by an occupational disease even if you don't lose time from work. People disabled by occupational diseases receive the same benefits they would for an on-the-job accident. In the case of death, the dependents must file within two years of the date of death.

The rules governing the time limits for filing an occupational disease claim are complex. You should file as soon as you know you're ill, or suspect that you have an occupational disease.

## Occupational Hearing Loss

The law states a different time period to file a claim for occupational hearing loss than from other disabilities. A waiting period must pass before you file a claim. That period is your choice of

- Three months after leaving the employment where you were exposed to the harmful noise, or
- Three months from the date you're removed from the harmful noise in the workplace. Removal can include wearing protective gear, so ask for it at work. You can contact OSHA at 1-800-321-OSHA for help if necessary.

The Board will consider the last day of whichever period you choose as the date of disability in determining when your benefits begin.

Occupational hearing loss claims have different time limits. You may file beyond the typical two-year limit if you do it within 90 days of learning the hearing loss is job-related.

## Wage Replacement (Cash) Benefits

Claimants who are totally or partially disabled for more than seven days receive benefits for lost wages. The amount you receive is based on your average weekly wage for the 52 weeks prior to the date of injury, including overtime. It's based on your gross earnings, not your take-home pay. The Board will use two-thirds of your average weekly wage, and then adjust it by the extent of your disability:

$$2/3 \times \text{average weekly wage} \times \% \text{ of disability} = \text{weekly benefit}$$

The weekly maximum benefit is two-thirds your average weekly wage. If you suffer a total disability, you get two-thirds your weekly wage, up to the maximum (see below). For example, if you earn \$750 per week and are totally (100%) disabled as of today, you receive two-thirds of \$750, or \$500 per week. You're 100% disabled, so you receive all of the benefit.

If you're 50% disabled and earned \$750 per week, your benefit is \$250. To calculate it: two-thirds your \$750 average weekly wage equals \$500. Then, because you are 50% disabled, your benefit is half of \$500, or \$250.

The benefit rate is computed the same way, whether you are temporarily or permanently disabled. The maximum weekly wage benefit is based on accident date. It does not increase as maximum benefits increase.

Date of Accident	Weekly Maximum Wage Benefit
July 1, 1992 - June 30, 2007	\$400
July 1, 2007 - June 30, 2008	\$500
July 1, 2008 - June 30, 2009	\$550
July 1, 2009 - June 30, 2010	\$600
July 1 each succeeding year	2/3 of NYSAWW*

\* The New York State Average Weekly Wage is calculated on March 31 for the previous calendar year.

If you're disabled more than 14 days, you may get wage benefits from the first day. Otherwise, the first 7 calendar days of the disability are not covered. Medical care for your injury is provided as long as it's needed, as determined by the Board.

**Note:** If the insurer disputes your case, it may withhold your wage replacement benefit until the Board directs it to pay you.

## Reduced Earnings Benefits

If you can return to work but your injury keeps you from earning the same wages you once did, you may be entitled to a benefit that will make up two-thirds of the difference. These are reduced earnings benefits.

## Disability Classifications

Your doctor will state how much your injury disables you. The insurer may disagree with that judgment. That insurer can require you to see a doctor it chooses for an *independent medical exam*. The Board will decide how disabled you are (the *degree of disability*) from among those opinions. Your lost wage benefit is based on degree of disability. There are four classes.

**Temporary Total Disability** You cannot work and earn wages, but only on a temporary basis. You're entitled to the full allowable wage benefit.

**Temporary Partial Disability** You've temporarily lost some ability to work and earn full wages. You'll receive a percentage of your salary equal to the percentage of disability. For example, if you're 25% disabled, you'll get 25% of your award, for the time you're disabled.

**Note:** All injuries, even those later found *permanent*, are first *temporary*. All benefits are also subject to the maximum weekly amount.

### **Permanent Partial Disability, Nonschedule Loss**

You lost some part of your ability to work. If you were injured before March 13, 2007, you can get benefits as long as the disability results in wage loss. Injuries after then may receive up to 10 years of benefits, as shown below. (You can apply for reclassification, and additional benefits, after that period.) Even if the disability doesn't impact wages, medical care is always paid.

### **Permanent Partial Disability, Schedule Loss**

This category involves loss of arm, hand, finger, leg, foot and toe or their use, and loss of eyesight or hearing. The law specifies the number of weeks in benefits you receive for this loss.

**Permanent Total Disability** You completely lost the ability to work and earn wages. **There's no limit on the number of weeks of benefits.**

**Note:** When suffering a partial disability, you must either remain employed, or seek employment within your abilities. Participating in a vocational rehabilitation program can meet that requirement.

### **Disfigurement**

People whose faces, head or neck are permanently disfigured may get up to \$20,000, depending upon the extent of injury and date of accident.

## Resolving Disputed Claims

Insurers will often accept a claim and promptly begin paying benefits. However, an insurer can dispute a claim, for various reasons. It may not agree you were injured, it may not believe the injury occurred while it provided insurance, or any number of other situations. Board claims examiners and conciliators first attempt to resolve issues. If they can't, the Board will hold hearings in front of a workers' compensation law judge. The judge takes testimony, reviews your medical records and wages. Then, the judge decides the issue, and sets the amount of any award.

Either side may appeal that decision. This must be done in writing within 30 days of the decision. Three Board commissioners review appealed cases. They may agree, change part of a decision, or reject it. They may also return the case for more hearings. Insurers don't have to pay lost wage benefits while the case is being reviewed by the three commissioners. An insurer can accept part of a case and appeal another. In that instance, it must pay the accepted part of the award while the case is reviewed. The insurer must pay your wages and medical bills if your award is upheld by those commissioners, even if it appeals further.

Either side may appeal that decision, to the full Board of workers' compensation commissioners. If the full Board takes the case, it will either agree, change or overturn the decision.

Appeals from Board decisions may be taken within 30 days to the Appellate Division, Third Department, Supreme Court of the State of New York. That decision may be appealed in the Court of Appeals.

You always have the right to an attorney or licensed representative. That person may not ask for or take a fee from you. The Board determines the fee for legal services.

**That fee is deducted from the lost wages award.**

## Disability Benefits During a Dispute

If you aren't receiving benefits because your claim was disputed, you may get disability benefits in the meantime. You can file a DB-450 form, available from [www.wcb.state.ny.us/content/main/forms/db450.pdf](http://www.wcb.state.ny.us/content/main/forms/db450.pdf) or by calling **1-800-353-3092**. You pay back any disability payments from your lost wage benefits.

## Death Benefits

There is a benefit for the family of workers who die from an injury or illness suffered on the job. The benefit is payable whether the worker dies right after an injury or later.

The worker's spouse and children will receive two-thirds of the employee's average weekly wage, up to the weekly maximum amount. The spouse and children share that weekly benefit; they do not each receive the full benefit. Children receive the benefit until age 18, or until 23 if they attend college. If a child is blind or physically disabled, he or she will receive the benefit for life. The spouse receives the benefit until remarriage. If the spouse remarries, he or she gets a final payment equal to two years of benefits.

The benefit is payable first to a spouse and minor children or dependent grandchildren. If there are no other dependents, then a different benefit is paid. The surviving parents or the deceased worker's estate may be entitled to \$50,000. Funeral expenses may also be paid. That benefit is up to \$6,000 in metropolitan New York counties, and up to \$5,000 in all others.

## Social Security Benefits

Your injury or illness may entitle you to Social Security Disability benefits, as well as workers' compensation. People with a permanent disability or a disability that lasts at least 12 months may qualify. Contact a Social Security Office to learn more.

## Discrimination

An employer may not fire you or hold it against you if you file a workers' compensation claim. You're also protected from retaliation for testifying in a workers' compensation case. Employers may not discriminate against you in hiring, too. You have two years to make a discrimination complaint. File Form DC-120 with the Board. You can call a Board office for the form, or find it at [www.wcb.state.ny.us/content/main/forms/dc120.pdf](http://www.wcb.state.ny.us/content/main/forms/dc120.pdf).

If the Board finds that a worker was improperly fired, it will order the employee restored. The employee will also receive back pay lost by that discrimination.

### AMERICANS WITH DISABILITIES ACT

The 1990 Americans with Disabilities Act prohibits discrimination against people with disabilities in employment. It ensures equal access to government services, public accommodations, transportation, and telecommunications. This law can help injured employees who want to return to work. Call the NYS Commission on Quality of Care and Advocacy for Persons with Disabilities at 1-800-949-4232 for more information.

## A Timeline for Your Case

**Immediately:** Get medical treatment. Tell your supervisor about the accident and how it occurred. You must also notify your employer of the accident, in writing, within 30 days. You should file a C-3 form with the Board, too.

**Within 48 hours of treatment:** Your doctor files a medical report with the Board. Copies must also be sent to you and your representative, and to the employer or its insurance carrier.

**Within 10 days of accident notification:** The employer reports the injury to the Board and the insurer on Form C-2.

**Within 14 days of receiving Form C-2:** The insurer gives you a written statement of your legal rights within 14 days of learning of the accident or with the first check, whichever is earlier. If you must use its provider network, the insurer must also give you that contact information.

**Within 18 days of receiving Form C-2:** The insurer must accept your claim or explain why it disputes it. It must inform you, any representative and the Workers' Compensation Board. If you didn't notify the employer promptly, it must act within 10 days of learning of the accident. If the case is disputed and you're losing time from work, file for disability benefits.

**Every 2 weeks:** The insurer pays lost wage benefits to you (if the case is accepted). It will pay your healthcare providers directly. The insurer must notify the Board if it stops or modifies your benefits.

**Periodically:** See your doctor and get treatment as recommended. The doctor will submit progress reports to the Board and insurer.

## Common Questions about the Law

**Q. What is covered under Workers' Compensation Law?**

**A.** Injuries on the job and work-related illnesses, as well as occupational diseases.

**Q. What if I don't file a claim for workers' compensation?**

**A.** You may lose the right to benefits for lost wages and medical care. You should file a C-3 reporting your own injury or illness, even though your employer's insurer must notify this Board when it accepts or disputes your case.

**Q. How is the cash benefit for temporary total disability determined?**

**A.** The temporary total disability benefit is two-thirds of the average weekly wage you earned in the year before the accident. There is a maximum amount you can receive per week (see page 6). Your maximum benefit is set by what is in effect **on the date of the injury**.

**Q. Is medical care provided even if no time is lost from work?**

**A.** Yes. Medical care is provided for your condition even if no time is lost from work.

**Q. Must I wait for medical care?**

**A.** No, but physicians must request authorization to perform procedures that cost more than \$1,000 each. This \$1,000 threshold pertains to each procedure, not the total cost of care. Insurers must respond to the request within 30 days. Authorization is not necessary in case of an emergency.

## Common Questions about the Law (continued)

**Q. May a doctor treat me if the insurer does not answer a request for approval?**

**A.** Yes. Insurers have 30 days to reply to an authorization request. If the insurer does not reply in 30 days, the provider may perform the services. If the service is a diagnostic test and the carrier requires claimants to use its network, the test must still be obtained from a network provider.

**Q. Are prescription medications covered under the law?**

**A.** Yes. Once your claim is established, pharmacies may bill the insurer directly. You may receive a card or document you can show a pharmacy stating you have coverage. If the carrier has a pharmacy network, it will tell you, and you must use those pharmacies. The only exceptions are in a medical emergency, or if the pharmacies don't offer mail order and there isn't a location reasonably close to you. You may have to pay the pharmacy for service before your claim is established. The carrier must then pay you when the case is established. There is no copayment.

**Q. What happens when an insurance carrier contests a claim?**

**A.** To contest a claim, a carrier must notify the Board within 18 days of the disability, or within 10 days of learning of the accident, whichever is later. The carrier must explain why it disputes the claim. You are then entitled to present your case to the Board. You will be notified of a pre-hearing conference. The Board seeks to resolve most cases within 90 days.

**Q. Must I have a medical examination when the employer or insurer requests it?**

**A.** Yes. The insurer may have you examined by a qualified provider who is authorized by this Board, within a reasonable distance for you to travel. Refusing this exam may affect your claim.

**Q. May an insurer suspend or change the cash benefits?**

**A.** Yes, but you are then entitled to a hearing. A carrier must submit evidence for the change to the Board, and the Board decides. A carrier may not change your benefit after the Board decides it without the Board's approval.

**Q. Do I have to use an attorney?**

**A.** No, but an attorney can be helpful in disputed and complex cases. You may represent yourself, or use an attorney or a licensed representative (list of licensed representatives is found at [www.wcb.state.ny.us/content/main/Reps/LisRepListing-Sec24a.pdf](http://www.wcb.state.ny.us/content/main/Reps/LisRepListing-Sec24a.pdf)). Any fees are approved by the Board, and deducted from your award. **Do not pay your counsel directly.**

**Q. What can I do if I disagree with the Board's decision?**

**A.** You may appeal in writing within 30 days of the filing date of the decision. You must explain why you disagree with the decision. Three Board commissioners will review your case. If you disagree with that review, you can appeal to the full Workers' Compensation Board of Commissioners. They may or may not consider it.

**Q. What can I do if I'm not satisfied with the outcome of the appeal?**

**A.** You may appeal to the Appellate Division, Third Department, within 30 days after the decision is served.

**Q. Are there penalties for falsehoods in claims?**

**A.** It's a felony to willfully misrepresent a case to obtain benefits. Penalties include up to seven years imprisonment and fines. A claimant may also lose the right to benefits. It's also a felony for an insurer to raise a false issue in an attempt to deny a worker benefits it knows the worker is entitled to receive.

# Directory of WCB Services and Board Offices

## *Board Services*

### **Customer Service**

1.877.632.4996

### **Advocate for Injured Workers**

1.800.580.6665

### **Health Care Provider**

1.800.781.2362

### **Administrative Review**

#### **Division**

1.877.258.3441

### **Fraud Referral Hotline**

1.888.363.6001

### **Disability Benefits**

1.800.353.3092

## *Board Offices*

### **Albany District Office**

100 Broadway - Menands

Albany, NY 12241

1.866.750.5157

### **Binghamton District Office**

State Office Bldg., 44 Hawley Street

Binghamton, NY 13901

1.866.802.3604

### **Buffalo District Office**

Cyclorama Building

369 Franklin Street

Buffalo, NY 14202

1.866.211.0645

### **Rochester District Office**

130 Main Street West

Rochester, NY 14614

1.866.211.0644

### **Syracuse District Office**

935 James Street

Syracuse, NY 13203

1.866.802.3730

**Send mail for these upstate districts  
directly to these addresses.**

### *Brooklyn District Office*

111 Livingston Street

Brooklyn, NY 11201

1.800.877.1373

### *Hauppauge District Office*

220 Rabro Drive, Suite 100

Hauppauge, NY 11788-4230

1.866.681.5354

### *Hempstead District Office*

175 Fulton Avenue

Hempstead, NY 11550

1.866.805.3630

### *Manhattan District Office*

215 W. 125th Street

New York, NY 10027

1.800.877.1373

### *Peekskill District Office*

41 North Division Street

Peekskill, NY 10566

1.866.746.0552

### *Queens District Office*

168-46 91st Avenue

Jamaica, NY 11432

1.800.877.1373

Claims-related mail for these  
districts should go to the *downstate*  
*centralized mailing address:*

**PO Box 5205 • Binghamton, NY •  
13902-5205**





# 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](http://www.wcb.state.ny.us).

WCB Case Number (if you know it): \_\_\_\_\_

### A. YOUR INFORMATION (Employee)

1. Name: \_\_\_\_\_ 2. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First MI Last
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: \_\_\_\_\_  
First MI Last

DATE OF INJURY/ILLNESS: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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.*



**Limited Release of Health Information  
(HIPAA)  
State of New York - Workers' Compensation Board**

**C-3.3**

WCB Case No. (if you know it): \_\_\_\_\_

**To Claimant:** If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

**To Health Care Provider:** A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

**A. YOUR INFORMATION (Claimant)**

1. Name: \_\_\_\_\_ 2. Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
3. Mailing Address: \_\_\_\_\_
4. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ 5. Date of the current injury/illness: \_\_\_\_/\_\_\_\_/\_\_\_\_
6. Current injury/illness, including all body parts injured: \_\_\_\_\_
7. Your legal representative's name and address (if any): \_\_\_\_\_

Check here if you allow your health care provider(s) to release **mental health care** information.

**B. YOUR HEALTH CARE PROVIDER(S)** (List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider: \_\_\_\_\_ 2. Phone Number: (\_\_\_\_) \_\_\_\_\_
3. Mailing Address: \_\_\_\_\_
4. Other provider (if any): \_\_\_\_\_ 5. Phone Number: (\_\_\_\_) \_\_\_\_\_
6. Mailing Address: \_\_\_\_\_

**C. READ AND SIGN BELOW.** I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

\_\_\_\_\_  
Claimant's signature Date

**If the claimant is unable to sign,** the person signing on his/her behalf must fill out and sign below:

\_\_\_\_\_  
Your name Relationship to Claimant Signature Date



# Divulgación limitada de información sobre la salud (HIPAA)

# C-3.3

## Estado de Nueva York - Junta de Compensación Obrera (WCB)

WCB Case No. (if you know it) (Número de caso WCB [si lo sabe])

**Al reclamante:** Si usted recibió tratamiento por una lesión anterior en la misma parte del cuerpo o por una enfermedad similar a la que motiva ahora su reclamación, complete este formulario. Este formulario le permite a los proveedores de salud que usted señala a continuación divulgar a la compañía de seguros de compensación obrera de su empleador la información sobre su salud relacionada con su lesión/enfermedad anterior. La Ley federal HIPAA (Ley de portabilidad y responsabilidad del seguro de salud de 1996) establece que usted tiene derecho a recibir una copia de este formulario. Si no comprende este formulario, hable con su representante legal. Si no tiene un representante legal, el Representante de los obreros lesionados de la Junta de Compensación Obrera puede ayudarlo. Llame al 800-580-6665.

**Al proveedor de salud:** Una **copia** de esta divulgación, redactada según lo que establece la ley HIPAA, le permite divulgar información sobre la salud. Si envía los registros al asegurador de compensación obrera del empleador en respuesta a la presente divulgación, también debe enviar por correo copias al representante legal del reclamante. (Si a continuación no se especifica un representante legal, envíe las copias al reclamante). Los proveedores de salud que divulgan los registros deben cumplir con las leyes del estado de Nueva York y la HIPAA.

Esta divulgación es:

- **Voluntaria.** Su(s) proveedor(es) de salud deben otorgarle la misma atención, condiciones de pago y beneficios, independientemente de que usted firme este formulario o no.
- **Limitada.** Le otorga a su(s) proveedor(es) de salud permiso para divulgar únicamente los registros médicos que se relacionen con la enfermedad/afección anterior que usted describe a continuación.
- **Temporal.** Termina cuando se otorgue o desestime su actual reclamación de compensación y se hayan agotado todas las apelaciones.
- **Revocable.** Usted puede cancelar esta divulgación en cualquier momento. Para hacerlo, envíe una carta al (a los) proveedor(es) de salud que se indican en este formulario. Además, envíe una copia de su carta a la compañía de seguros de compensación obrera de su empleador y a la Junta de Compensación Obrera. *Nota: No podrá cancelar esta divulgación en lo que se refiere a registros médicos que ya se hayan provisto.*
- **Solamente para registros.** Le otorga a su(s) proveedor(es) de salud que se indica(n) en este formulario permiso para enviar copias de sus registros de salud a la compañía de seguros de compensación obrera de su empleador.

Este formulario NO autoriza a su(s) proveedor(es) de salud a divulgar los siguientes tipos de información:

- Información relacionada con el VIH
- Notas de terapia psicológica
- Tratamientos por abuso de alcohol o drogas
- Tratamiento de salud mental (a menos que usted lo indique a continuación)
- Información verbal (sus doctores no pueden hablar con nadie sobre su información de salud)

Los registros médicos divulgados se incorporarán a su expediente de compensación obrera y son confidenciales conforme a la Ley de compensación obrera.

CONTESTA LAS SIGUIENTES PREGUNTAS, EN INGLÉS SI ES POSIBLE, EN LOS ESPACIOS PROVISTOS Y FIRMA AL FRENTE DE LA FORMA.

**A. YOUR INFORMATION (Claimant) INFORMACIÓN PERSONAL (Reclamante)**

1. Name (Nombre) 2. Social Security Number (Número de seguro social)
3. Mailing Address (Dirección postal)
4. Date of Birth (Fecha de nacimiento) 5. Date of the current injury/illness (Fecha de la lesión/enfermedad actual)
6. Current injury/illness, including all body parts injured (Descripción de la lesión/enfermedad actual, incluyendo todas las partes del cuerpo lesionadas)
7. Your legal representative's name and address (if any) (Nombre y dirección de su representante legal [si corresponde])  
*Check here if you allow your health provider(s) to release **mental health care** information. (Marque aquí si autoriza a su(s) proveedor(es) de salud a divulgar información sobre **tratamientos de salud mental**.)*

**B. YOUR HEALTH CARE PROVIDERS** (List all health care providers who treated you for a previous injury to the same body part or similar illness. If more than 2 providers, attach their contact information to this form.)

**SU(S) PROVEEDOR(ES) DE SALUD** (Enumere todos los proveedores de salud que le han tratado por lesiones previas a las mismas áreas del cuerpo ó por enfermedades semejantes. Si son más de 2 proveedores, adjunte su información de contacto a este formulario.)

1. Provider (Proveedor de salud) 2. Phone Number (N° de teléfono)
3. Mailing Address (Dirección postal)
4. Other provider (if any) (Otro proveedor [si corresponde]) 5. Phone Number (N° de teléfono)
6. Mailing Address (Dirección postal)

**C. READ AND SIGN BELOW**

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above. **LEA Y FIRME A CONTINUACIÓN.** Por la presente solicito que los proveedores de salud aquí enumerados le provean al asegurador de compensación obrera de mi patrono copias de todos los records médicos relacionados a cualquier lesión/enfermedad aquí enumeradas.

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below: **(Si el reclamante no puede firmar, la persona que firme el formulario en su nombre y representación debe llenar y firmar a continuación)**

XX  
Claimant's signature (Firma del reclamante) Date (Fecha)

XX  
Your name (Su nombre) Relationship to Claimant (Relación con el reclamante) Signature (Firma) Date (Fecha)

## Instructions for Completing Form C-3, "Employee Claim for Compensation"

Please complete this form and send it to your local Workers' Compensation Board district office (DO) to apply for workers' compensation benefits. The addresses are listed at the bottom of these instructions. If you need additional help in completing this form, contact the Workers' Compensation Board at 1-877-632-4996. You may also fill this form out online at: <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 your claim. Remember to enter your name and the date of your injury/illness on the top of page two.**

### Section A - Your Information (Employee):

- Item 1:** Enter your full name, including first name, middle initial, and last name.
- Item 2:** Enter your date of birth in month/day/year format. Include the four digit year.
- Item 3:** Enter your mailing address, including P.O. Box, if applicable, city or town, state, and Zip code.
- Item 4:** Enter your Social Security Number. This is very important to help service your claim faster.
- Item 5:** Indicate the primary contact phone number, including area code. This may include a cell phone number.
- Item 6:** Indicate your gender (Male or Female).
- Item 7:** Check Yes if you can speak and understand English. If not, then check No and indicate which language you speak.

### Section B - Your Employer(s):

- Item 1:** Indicate the employer you were working for at the time you were injured or became ill.
- Item 2:** Enter the phone number for this employer, either a primary contact number or the number for your supervisor.
- Item 3:** Enter the employer's address, including P.O. Box, if applicable, city or town, state, and Zip code.
- Item 4:** Indicate the date you were hired by this employer.
- Item 5:** Enter your direct supervisor's name, whom you report to on a regular basis.
- Item 6:** If you have more than one job, please indicate the names and addresses of all other employers you work for besides the one you were injured at. Please attach a separate sheet if you need more room.
- Item 7:** Check Yes if you lost time from any of your other jobs as a result of your injury or illness; otherwise, check No.

### Section C - Your Job on the Date of the Injury or Illness:

- Item 1:** Indicate your current job title or job description (e.g., warehouse worker).
- Item 2:** Indicate your typical work activities for this job (e.g., keeping inventory, unloading trucks, etc.).
- Item 3:** Check the type of job you had.
- Item 4:** Enter your gross pay (before taxes) per pay period.
- Item 5:** Indicate how often you received a paycheck (weekly, bi-weekly, etc.).
- Item 6:** Indicate if you received any tips or lodging in addition to your regular pay. If you did, describe them.

### Section D - Your Injury or Illness:

- Item 1:** Enter the date when you were injured or the first date you noticed you became ill. Enter the date in month/day/year format. Include the four digit year. If this is an illness or occupational disease, then skip item 2.
- Item 2:** Enter the time when the injury occurred. Check whether it was AM or PM.
- Item 3:** 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 4:** Check whether this was your normal work location. If it was not, explain why you were at this location.
- Item 5:** Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.
- Item 6:** Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
- Item 7:** Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible. (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now.)
- Item 8:** Indicate if some object was involved in the accident OTHER THAN a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
- Item 9:** Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.
- Item 10:** Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.
- Item 11:** Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

### Section E - Return to Work:

- Item 1:** If you stopped working as a result of your work-related injury/illness, check Yes and indicate on what date you stopped working. If you have not stopped working, check No and skip to the next section.

### **Section E - Return to Work (cont):**

- Item 2:** If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)
- Item 3:** If you have returned to work, indicate who you are working for now.
- Item 4:** Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

### **Section F - Medical Treatment for This Injury or Illness:**

- Item 1:** If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.
- Item 2:** Check if you were first treated on the job for this injury or illness.
- Item 3:** Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).
- Item 4:** If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise check No.
- Item 5:** If you believe you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**
- Item 6:** If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 on the bottom of the second page, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line.

### **What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:**

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the nearest Workers' Compensation Board Office. (See below.) Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, telephone or visit the nearest Workers' Compensation Board Office listed below.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

### **Your Rights:**

1. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed, the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, his/her fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

**This form should be filed by sending directly to the appropriate WCB district office (DO) at the address listed below:**

**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 NY 13901 (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 Peekskill (866) 746-0552** (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)



# Doctor's Initial Report

# C-4

State of New York - Workers' Compensation Board

Use this form to report the *first* time you treated the patient. (To report continued treatment, use Form C-4.2. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.state.ny.us](http://www.wcb.state.ny.us).

## A. Patient's Information

- 1. Name: \_\_\_\_\_ 2. Social Security #: \_\_\_\_\_  
Last First MI
- 3. Home phone #: (\_\_\_\_) \_\_\_\_\_ 4. WCB Case # (if known): \_\_\_\_\_ 5. Carrier Case #: \_\_\_\_\_
- 6. Mailing address: \_\_\_\_\_  
Number and Street City State Zip Code
- 7. Date of injury/onset of illness: \_\_\_\_/\_\_\_\_/\_\_\_\_ 8. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ 9. Gender:  Male  Female
- 10. On the date of injury/illness what was the patient's job title or description: \_\_\_\_\_
- 11. On the date of injury/illness what were the patient's usual work activities: \_\_\_\_\_  
 \_\_\_\_\_
- 12. Patient's Account #: \_\_\_\_\_

## B. Employer Information

- 1. Employer when injury occurred: \_\_\_\_\_ 2. Phone #: (\_\_\_\_) \_\_\_\_\_  
Company/Agency Name
- 3. Employer Address: \_\_\_\_\_  
Number and Street City State Zip Code

## C. Doctor's Information

- 1. Your name: \_\_\_\_\_ 2. WCB Authorization #: \_\_\_\_\_  
Last First MI
- 3. WCB Rating Code: \_\_\_\_\_ 4. Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one):  SSN  EIN
- 5. Office address: \_\_\_\_\_  
Number and Street City State Zip Code
- 6. Billing group or practice name: \_\_\_\_\_
- 7. Billing address: \_\_\_\_\_  
Number and Street City State Zip Code
- 8. Office phone #: (\_\_\_\_) \_\_\_\_\_ 9. Billing phone #: (\_\_\_\_) \_\_\_\_\_ 10. Treating Provider's NPI #: \_\_\_\_\_
- 11. You are a (check one):  Physician  Podiatrist  Chiropractor

## D. Billing Information

- 1. Employer's insurance carrier: \_\_\_\_\_ 2. Carrier Code #: **W** \_\_\_\_\_
- 3. Insurance carrier's address: \_\_\_\_\_  
Number and Street City State Zip Code
- 4. Diagnosis or nature of disease or injury:  
 Enter ICD9 Code: ICD9 Descriptor:  
 (1) \_\_\_\_\_  
 (2) \_\_\_\_\_  
 (3) \_\_\_\_\_  
 (4) \_\_\_\_\_

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column on page 2 by line.

Patient's Name: \_\_\_\_\_  
Last First MI

Date of injury/onset of illness: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/ Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			Procedures, Services or Supplies CPT/HCPCS	MODIFIER					

Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge \$	Amount Paid (Carrier Use Only) \$	Balance Due (Carrier Use Only) \$
--------------------	---	---

**E. History**

- Based on the patient's history, where and how did the injury/illness happen: \_\_\_\_\_  
 \_\_\_\_\_
- How did you learn about the injury/illness (check one):  Patient  Medical Records  Other(specify): \_\_\_\_\_
- Did another health provider treat this injury/illness including hospitalization and/or surgery?  Yes  No If yes, give details: \_\_\_\_\_
- Have you previously treated this patient for a similar work-related injury/illness?  Yes  No If yes, when: \_\_\_\_\_

**F. Exam Information**

- Date(s) of Examination: \_\_\_\_\_
- Patient's subjective complaints: Check all that apply and identify specific affected body part(s).
 

<input type="checkbox"/> Numbness/Tingling _____	<input type="checkbox"/> Swelling _____
<input type="checkbox"/> Pain _____	<input type="checkbox"/> Weakness _____
<input type="checkbox"/> Stiffness _____	<input type="checkbox"/> Other (specify) _____
- Type/nature of injury: Check all that apply and identify specific affected body part(s).
 

<input type="checkbox"/> Abrasion _____	<input type="checkbox"/> Infectious Disease _____
<input type="checkbox"/> Amputation _____	<input type="checkbox"/> Inhalation Exposure _____
<input type="checkbox"/> Avulsion _____	<input type="checkbox"/> Laceration _____
<input type="checkbox"/> Bite _____	<input type="checkbox"/> Needle Stick _____
<input type="checkbox"/> Burn _____	<input type="checkbox"/> Poisoning/Toxic Effects _____
<input type="checkbox"/> Contusion/Hematoma _____	<input type="checkbox"/> Psychological _____
<input type="checkbox"/> Crush Injury _____	<input type="checkbox"/> Puncture Wound _____
<input type="checkbox"/> Dermatitis _____	<input type="checkbox"/> Repetitive Strain Injury _____
<input type="checkbox"/> Dislocation _____	<input type="checkbox"/> Spinal Cord Injury _____
<input type="checkbox"/> Fracture _____	<input type="checkbox"/> Sprain/Strain _____
<input type="checkbox"/> Hearing Loss _____	<input type="checkbox"/> Torn Ligament, Tendon or Muscle _____
<input type="checkbox"/> Hernia _____	<input type="checkbox"/> Vision Loss _____
<input type="checkbox"/> Other (specify) _____	



Patient's Name: \_\_\_\_\_ Date of injury/onset of illness: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

4. Physical examination: *Check all relevant objective findings and identify specific affected body part(s).*

- |   |   |
|---|---|
| <input type="checkbox"/> None at present              | <input type="checkbox"/> Neuromuscular Findings:      |
| <input type="checkbox"/> Bruising _____               | <input type="checkbox"/> Abnormal/Restricted ROM      |
| <input type="checkbox"/> Burns _____                  | <input type="checkbox"/> Active ROM _____             |
| <input type="checkbox"/> Crepitation _____            | <input type="checkbox"/> Passive ROM _____            |
| <input type="checkbox"/> Deformity _____              | <input type="checkbox"/> Gait _____                   |
| <input type="checkbox"/> Edema _____                  | <input type="checkbox"/> Palpable Muscle Spasm _____  |
| <input type="checkbox"/> Hematoma/Lump/Swelling _____ | <input type="checkbox"/> Reflexes _____               |
| <input type="checkbox"/> Joint Effusion _____         | <input type="checkbox"/> Sensation _____              |
| <input type="checkbox"/> Laceration/Sutures _____     | <input type="checkbox"/> Strength (Weakness) _____    |
| <input type="checkbox"/> Pain/Tenderness _____        | <input type="checkbox"/> Wasting/Muscle Atrophy _____ |
| <input type="checkbox"/> Scar _____                   |   |
| <input type="checkbox"/> Other findings: _____        |   |

5. Describe any diagnostic test(s) rendered at this visit: \_\_\_\_\_  
\_\_\_\_\_

6. Describe any treatment(s) rendered at this visit: \_\_\_\_\_  
\_\_\_\_\_

7. Describe prognosis for recovery: \_\_\_\_\_  
\_\_\_\_\_

8. Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis?  Yes  No  
If yes, list and describe: \_\_\_\_\_  
\_\_\_\_\_

### G. Doctor's Opinion

- In your opinion, was the incident that the patient described the competent medical cause of this injury/illness?  Yes  No
- Are the patient's complaints consistent with his/her history of the injury/illness?  Yes  No
- Is the patient's history of the injury/illness consistent with your objective findings?  Yes  No  N/A (no findings at this time)
- What is the percentage (0-100%) of temporary impairment? \_\_\_\_\_%
- Describe findings and relevant diagnostic test results: \_\_\_\_\_  
\_\_\_\_\_

### H. Plan of Care

- What is your proposed treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Medication(s):(a) list medications prescribed: \_\_\_\_\_  
(b) list over-the-counter medications advised: \_\_\_\_\_  
Medication restrictions:  None  May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below:  
\_\_\_\_\_  
\_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of injury/onset of illness: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

3. Does the patient need diagnostic tests or referrals?  Yes  No If yes, check all that apply:

**Tests:**

- CT Scan
- EMG/NCS
- MRI (Specify): \_\_\_\_\_
- Labs (Specify): \_\_\_\_\_
- X-rays (Specify): \_\_\_\_\_
- Other (Specify): \_\_\_\_\_

**Referrals:**

- Chiropractor
- Internist/Family Physician
- Occupational Therapist
- Physical Therapist
- Specialist in \_\_\_\_\_
- Other (Specify): \_\_\_\_\_

4. Assistive devices prescribed for this patient:  Cane  Crutches  Orthotics  Walker  Wheelchair  
 Other (specify): \_\_\_\_\_

**Important:** Form C-4 AUTH should be utilized to request any special medical service over \$1000.

5. When is the patient's next follow-up appointment?

- Within a week
- 1-2 weeks
- 3-4 weeks
- 5-6 weeks
- 7-8 weeks
- \_\_\_\_\_ months
- Return as needed

## I. Work Status

1. Has the patient missed work because of the injury/illness?  Yes  No If yes, date patient first missed work: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is the patient currently working?  Yes  No If yes, did the patient return to:  usual work activities  limited work activities

2. Can the patient return to work? (check *only one*):

- a.  The patient cannot return to work because (explain): \_\_\_\_\_
- b.  The patient can return to work without limitations on \_\_\_\_/\_\_\_\_/\_\_\_\_
- c.  The patient can return to work with the following limitations (check all that apply) on \_\_\_\_/\_\_\_\_/\_\_\_\_
  - Bending/twisting
  - Climbing stairs/ladders
  - Environmental conditions
  - Kneeling
  - Other (explain): \_\_\_\_\_
  - Lifting
  - Operating heavy equipment
  - Operation of motor vehicles
  - Personal protective equipment
  - Sitting
  - Standing
  - Use of public transportation
  - Use of upper extremities

Describe/quantify the limitations: \_\_\_\_\_

How long will these limitations apply?  1-2 days  3-7 days  8-14 days  15+ days  Unknown at this time  N/A

3. With whom will you discuss the patient's return to work and/or limitations?  with patient  with patient's employer  N/A

**This form is signed under penalty of perjury.**

**Board Authorized Health Care Provider - Check one:**

- I provided the services listed above.
- I actively supervised the health-care provider named below who provided these services.

Provider's name \_\_\_\_\_ Specialty \_\_\_\_\_

**Board Authorized Health Care Provider signature:**

\_\_\_\_\_  
Name Signature Specialty Date

**MEDICAL REPORTING****IMPORTANT-TO THE ATTENDING DOCTOR**

- This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases as follows:  
**48 HOUR INITIAL REPORT** - Prepare and submit this form, complete in all details, within 48 hours after you first render treatment.  
 If you continue to treat, use form C-4.2 for future reporting. DO NOT use this form for future reporting.  
 All reports are to be filed with the Workers' Compensation Board, the workers' compensation insurance carrier, self-insured employer, and if the patient is represented by an attorney or licensed representative, with such representative. If the claimant is not represented, a copy must be sent to the claimant.  
 Ophthalmologists use form C-5, Occupational/Physical Therapists use form OT/PT-4 and Psychologists use form PS-4 for filing reports.
- Please ask your patient for his/her WCB Case Number and the Insurance Carrier's Case Number, if they are known to him/her, and show these numbers on your reports. In addition, ask your patient if he/she has retained a representative. If so, ask for the name and address of the representative. You are required to send copies of all reports to the patient's representative, if any.
- This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. If the patient is hospitalized, it may be signed by a licensed doctor to whom the treatment of the case has been assigned as a member of the attending staff of the hospital.
- AUTHORIZATION FOR SPECIAL SERVICES** - Form C-4 AUTH should be utilized to request any special medical service over \$1000.  
**AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY**
- LIMITATION OF PODIATRY TREATMENT** - Podiatry treatment is limited as defined in Section 7001 of the Education Law and Section 13-k(2) of the Workers' Compensation Law.
- LIMITATION OF CHIROPRACTIC TREATMENT** - Chiropractic treatment is limited as defined in Section 6551 of the Education Law and the Chair's Rules Relative to Chiropractic Practice Under Section 13-l of the Workers' Compensation Law.  
**A CHIROPRACTOR OR PODIATRIST FILING THIS REPORT CERTIFIES THAT THE INJURY DESCRIBED CONSISTS SOLELY OF A CONDITION(S) WHICH MAY LAWFULLY BE TREATED AS DEFINED IN THE EDUCATION LAW AND, WHERE IT DOES NOT, HAS ADVISED THE INJURED PERSON TO CONSULT A PHYSICIAN OF HIS/HER CHOICE.**
- HIPAA NOTICE** - In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

**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.**

**BILLING INFORMATION**

Complete all billing information contained on this form. Use continuation Form C-4.1, if necessary. The workers' compensation carrier has 45 days to pay your bill or to file an objection to it. Contact the workers' compensation carrier if you receive neither payment nor an objection within this time period. After contacting the carrier, you may, if necessary, contact the Board's Disputed Bill Unit, at the Albany address indicated below, for information/assistance.

**IMPORTANT TO THE PATIENT**

**YOUR DOCTORS' BILLS (AND BILLS FOR HOSPITALS AND OTHER SERVICES OF A MEDICAL NATURE) WILL BE PAID BY YOUR EMPLOYER, THE LIABLE POLITICAL SUBDIVISION OR ITS INSURANCE COMPANY OR THE UNAFFILIATED VOLUNTEER AMBULANCE SERVICE IF YOUR CLAIM IS ALLOWED. DO NOT PAY THESE BILLS YOURSELF, UNLESS YOUR CASE IS DISALLOWED OR CLOSED FOR FAILURE TO PROSECUTE.**

IF YOU HAVE ANY QUESTIONS CONCERNING THIS NOTICE OR YOUR CASE, OR WITH RESPECT TO YOUR RIGHTS UNDER THE WORKERS' COMPENSATION LAW, OR THE VOLUNTEER FIREFIGHTERS' OR VOLUNTEER AMBULANCE WORKERS' LAWS, YOU SHOULD CONSULT THE NEAREST OFFICE OF THE BOARD FOR ADVICE. ALWAYS USE THE CASE NUMBERS SHOWN ON THE OTHER SIDE OF THIS NOTICE, OR ON OTHER PAPERS RECEIVED BY YOU, IF YOU FIND IT NECESSARY TO COMMUNICATE WITH THE BOARD OR THE CARRIER. ALSO, MENTION YOUR SOCIAL SECURITY NUMBER IF YOU WRITE OR CALL THE BOARD.

**IMPORTANTE PARA EL PACIENTE**

**LAS FACTURAS POR SERVICIOS MEDICOS INCLUYENDO HOSPITALES Y TODO SERVICIO DE NATURALEZA MEDICA SERA PAGADO POR EL PATRONO O POR LA ENTIDAD RESPONSABLE O SU COMPANIA DE SEGUROS SEGUN SEA EL CASO; SI SU RECLAMACION ES APROBADA. NO PAGUE ESTAS FACTURAS A MENOS QUE SU CASO SEA DESESTIMADO EN SU FONDO O ARCHIVADO POR NO REALIZAR LOS TRAMITES CORRESPONDIENTES.**

**SI USTED TIENE ALGUNA PREGUNTA, EN RELACION A ESTA NOTIFICACION O A SU CASO O EN RELACION A SUS DERECHOS BAJO LA LEY DE COMPENSACION OBRERA O LA LEY DE BOMBEROS VOLUNTARIOS O LA LEY DE SERVICIOS DE AMBULANCIAS VOLUNTARIOS DEBE COMUNICARSE CON LA OFICINA MAS CERCA DE LA JUNTA PARA ORIENTACION. SIEMPRE USE EL NUMERO DEL CASO QUE APARECE EN LA PARTE DEL FRENTE DE ESTA NOTIFICACION, O EN OTROS DOCUMENTOS RECIBIDOS POR USTED. SI LE ES NECESARIO COMUNICARSE CON LA JUNTA O CON EL "CARRIER."**

TAMBIEN MENCIONE EN SU COMUNICACION ORAL O ESCRITA SU NUMERO DE SEGURO SOCIAL.

**WORKERS' COMPENSATION BOARD DISTRICT OFFICES**

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 NY 13901 866-802-3604** (for accidents in the following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)
- Buffalo DO - 369 Franklin Street, 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 Peekskill 866-746-0552** (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)

Statewide Fax Line: 877-533-0337