

INSTRUCTIONS TO EMPLOYERS: reports should be sent directly to the district offices at these addresses:

- ALBANY 12241 - 100 Broadway, Menands. (866) 750-5157** For all accidents in following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington.
- BINGHAMTON 13901 - State Office Building, 44 Hawley Street. (866) 802-3604** For all accidents in following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuylar, Sullivan, Tioga, Tompkins.
- BUFFALO 14202 - Statler Towers, 107 Delaware Ave. (866) 211-0645** For all accidents in following counties: Cattaraugus, Chautauqua, Erie, Niagara.
- ROCHESTER 14614 - 130 Main Street West. (866) 211-0644** For all accidents in following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates.
- SYRACUSE 13203 - 935 James Street. (866) 802-3730** For all accidents in following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence.
- DOWNSTATE CENTRALIZED MAILING (for New York City, Hempstead, Hauppauge & Peekskill district offices) - PO Box 5205, Binghamton, NY 13902-5205. NYC (800) 877-1373 Hemp. (866) 805-3630 Haup. (866) 681-5354 Peek. (866) 746-0552** For all accidents in following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester.

WORKERS' COMPENSATION LAW

Section 13 Treatment and care of injured employees.

(a) "The employer shall promptly provide for an injured employee such medical, surgical, optometric or other attendance or treatment, nurse and hospital service, medicine, optometric services, crutches, eye-glasses, false teeth, artificial eyes, orthotics, functional assistive and adaptive devices and apparatus for such period as the nature of injury or the process of recovery may require.*****"

Section 13 Injury to employee's prosthesis.

(a) "Damage to or loss of a prosthetic device shall be deemed an injury except that no disability benefits shall be payable with respect to such injury under section fifteen of this article.*****"

Section 25 Effect of failure to file reports.

3. (e) "If the employer or its insurance carrier fails to file a notice or report requested or required by the board or chair or otherwise required within the specified time period or within ten days if no time period is specified, the board may impose a penalty in the amount of fifty dollars.*****"

Section 51 Posting of notice regarding compensation.

"Every employer who has complied with section fifty of this chapter shall post and maintain in a conspicuous place or places in and about his place or places of business typewritten or printed notices in form prescribed by the chairman, stating the fact that he has complied with all the rules and regulations of the chairman and the board and that he has secured the payment of compensation to his employees and their dependents in accordance with the provisions of this chapter, but failure to post such notice as herein provided shall not in any way affect the exclusiveness of the remedy provided for by section eleven of this chapter.*****"

Section 52 Effect of failure to secure compensation.

1. (a) "Failure to secure the payment of compensation shall constitute a misdemeanor, punishable by a fine of not less than five hundred nor more than two thousand five hundred dollars or imprisonment for not more than one year, or both.

(b) Where any person has previously been convicted of a failure to secure the payment of compensation within the preceding five years, upon conviction for a second violation such person shall be fined not less than one thousand nor more than five thousand dollars in addition to any other penalties including fines otherwise provided by law, and upon conviction for a third or subsequent violation such person may be fined up to seven thousand five hundred dollars in addition to any other penalties including fines otherwise provided by law.

(c) Where the employer is a corporation, the president, secretary and treasurer thereof shall be liable for failure to secure the payment of compensation under this section.*****"

Section 110 Record and report of injuries by employers.

1. An employer, or a third party designated by the employer, shall record any injury or illness incurred by one of its employees in the course of employment using the form prescribed by the chair for reporting injuries under subdivision two of this section. Such form, a copy of which shall be provided to the injured employee upon request, shall be maintained by the employer, or a third party designated by the employer, for at least eighteen years, and shall be subject to review by the chair at any time. Such form need not be filed with the chair unless the status of such injury or illness changes resulting in a loss of time from regular duties or in medical treatment which would require reporting in accordance with subdivision two of this section.

2. An employer, or a third party designated by the employer, shall file with the chair of the workers' compensation board and with the carrier if the employer is insured, upon a form prescribed by the chair, a report of any accident resulting in personal injury which has caused or will cause a loss of time from regular duties of one day beyond the working day or shift on which the accident occurred, or which has required or will require medical treatment beyond ordinary first aid or more than two treatments by a person rendering first aid. Such report shall state the name and nature of the business of the employer, the location of its establishment or place of work, the name, address and occupation of the injured employee, the time, nature and cause of the injury and such other information as may be required by the chair. Such report shall be filed within ten days after the occurrence of the accident. An employer shall furnish a report of an occupational disease incurred by an employee in the course of his or her employment, to the chair of the workers' compensation board, and to the carrier if the employer is insured, upon the same form. The carrier, within fourteen days of receipt of the report or accompanying the initial check forwarded to the employee, whichever is earlier, or a self-insured employer, within fourteen days of transmitting the report to the chair or accompanying the initial check forwarded to the employee, whichever is earlier, shall provide the injured employee or, in the case of death, his or her dependents with a written statement of their rights under this chapter, in a form prescribed by the chair. An employer shall file a report of any other accident resulting in personal injury incurred by its employee in the course of employment, upon the same form, whenever directed by the chair.

3. Any injury or illness which is not required to be reported in accordance with subdivision two of this section, shall not be used as a basis for determining experience modification rates, provided the employer pays in the first instance or reimburses the employer's insurer for the treatment rendered to the employee.

4. An employer who refuses or neglects to make a report or to keep records as required by this section shall be guilty of a misdemeanor, punishable by a fine of not more than one thousand dollars. The board or chair may impose a penalty of not more than two thousand five hundred dollars upon an employer who refuses or neglects to make such report.

5. The chair shall be authorized to promulgate regulations necessary to carry out the provisions of this section.

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

EMPLOYER'S REPORT OF WORK-RELATED ACCIDENT/OCCUPATIONAL DISEASE

Send this notice directly to the Chair, Workers' Compensation Board at the address shown on the reverse side within ten (10) days after an accident occurs. ANSWER ALL QUESTIONS FULLY. A copy should also be provided to or retained by your workers' compensation insurance carrier.

Any employer who fails to timely file Form C-2, as required by Section 110 of the Workers' Compensation Law, is subject to a fine of not more than \$1,000. In addition, the Board or Chair may impose a penalty of up to \$2,500.

TYPEWRITER PREPARATION IS STRONGLY RECOMMENDED - INCLUDE ZIP CODE IN ALL ADDRESSES-EMPLOYEE'S S.S.NO. MUST BE ENTERED BELOW

WCB CASE NO.(If Known)		CARRIER CASE NO.		CARRIER CODE NO.		WC POLICY NO.		DATE OF ACCIDENT				EMPLOYEE'S S.S. NO.							
				W				m	m	d	d	y	y						
1.(a) EMPLOYER'S NAME				(b) EMPLOYER'S MAILING ADDRESS				(c) OSHA CASE/FILE NO.											
(d) LOCATION (If Different From Mailing Address)				(e) NATURE OF BUSINESS (Principal Products, Services, etc.)				(f) NY UI EMPLOYER REG. NO.				(g) FEIN - if UI Emp. Reg. No. Unknown							
2.(a) INSURANCE CARRIER						(b) CARRIER'S ADDRESS													
3.(a) INJURED EMPLOYEE (First, M.I., Last)						(b) ADDRESS (Includes No. & Street, City, State, Zip & Apt. No.)													
A C C I D E N T	4. (a) ADDRESS WHERE ACCIDENT OCCURRED						(b) COUNTY				(c) WAS ACCIDENT ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	5. HOUR EMP. BEGAN WORK		6. TIME OF ACCIDENT		7. DEPT. WHERE REGULARLY EMPLOYED		8.(a) DATE STOPPED WORK BECAUSE OF THIS INJURY/ILLNESS				(b) WAS EMPLOYEE PAID IN FULL FOR DAY? <input type="checkbox"/> Yes <input type="checkbox"/> No								
I N J U R E D	9. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		10. DATE OF BIRTH		11. OCCUPATION (Specific job title at which employed)				12. DATE HIRED										
N A T U R E O F I N J U R Y	13.(a) AVERAGE EARNINGS PER WEEK?		(b) TOTAL EARNINGS PAID DURING 52 WEEKS PRIOR TO DATE OF ACCIDENT (Include bonuses, overtime, value of lodging, etc.)		14. (a) EMPLOYEE IS:		(b) INJURED EMPLOYEE'S WORK WEEK (Check days usually worked.)												
					<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		Mon	Tue	Wed	Thu	Fri	Sat	Sun						
C A U S E O F A C C I D E N T	15. NATURE OF INJURY AND PART(S) OF BODY AFFECTED						16. (a) DID YOU PROVIDE MEDICAL CARE? <input type="checkbox"/> Yes <input type="checkbox"/> No				(b) IF YES, WHEN?								
	17. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> Yes <input type="checkbox"/> No						18. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? <input type="checkbox"/> Yes <input type="checkbox"/> No												
	19. (a) NAME AND ADDRESS OF DOCTOR						(b) NAME AND ADDRESS OF HOSPITAL												
F A T A L C A S E S	20. (a) HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No				(b) IF YES, GIVE DATE:				(c) AT WHAT WEEKLY WAGE?										
P R E P A R A T I O N	NOTE: FORM C-11 MUST BE FILED EACH TIME THERE IS A CHANGE IN EMPLOYMENT STATUS																		
	21. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.)																		
	22. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)																		
23. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE. e.g., the machine employee struck against or which struck him/her, the vapor or poison inhaled or swallowed, the chemical that irritated his/her skin. In cases of strains, the thing (s)he was lifting, pulling, etc.																			
24. (a) DATE OF DEATH		(b) NAME AND ADDRESS OF NEAREST RELATIVE						(c) RELATIONSHIP											
DATE EMPLOYER/SUPERVISOR FIRST KNEW OF INJURY				DATE OF THIS REPORT				IF FORM IS SUBMITTED BY EMPLOYER, COMPLETE A & B BELOW.				IF FORM IS SUBMITTED BY THIRD PARTY, COMPLETE A,B,C & D BELOW.							
A. EMPLOYEE PREPARING FORM OR SUPPLYING INFORMATION TO THIRD PARTY						B. TITLE						TELEPHONE NUMBER & EXTENSION							
C. IF REPORT PREPARED BY THIRD PARTY, COMPANY NAME AND ADDRESS																			
D. THIRD PARTY CONTACT NAME																			
TELEPHONE NUMBER & EXTENSION																			

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