

Employee Claim
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.ny.gov.

W	CB Case Number (if you know it):			
A.	YOUR INFORMATION (Employee)  1. Name:			
	3. Mailing address:  Number and Street/PO Box/Apartment No.  City State Zip Code			
	4. Social Security Number: 5. Phone Number: () 6. Gender:			
B.	7. Will you need a translator if you have to attend a Board hearing?  Yes No If yes, for what language? YOUR EMPLOYER(S)			
	1. Employer when injured:			
	3. Your work address:			
	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:			
C.	7. Did you lose time from work at the other employment(s) as a result of your injury/illness? Yes No YOUR JOB on the date of the injury or illness			
	What two of patritics did your remail to the second s			
	2. What types of activities did you normally perform at work?			
	3. Was your job? (check one)			
	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:			
	OUR 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?			
1000	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):			

First		
). YOUR INJURY OR ILLN	ESS continued	ATE OF INJURY/ILLNESS:/
	hammer, acid) involved in the injury/illness?	No If yes, what?
		s $\square$ No
If yes,  your vehicle		e plate number (if known):
If your vehicle was involved	l, give name and address of your motor vehicle insurance of	carrier:
10. Have you given your employ	/er (or supervisor) notice of injury/illness?	No
If yes, notice was given to: _	orally	in writing Date notice given: / /
11. Did anyone see your injury h	nappen? Yes No Unknown If yes, list name	es:
E. RETURN TO WORK		
	of your injury/illness?	/ District Out of
		The second secon
3. If you have returned to work	Yes No If yes, on what date?//	
4. What is your gross pay /befo	, who are you working for now? Same employer	☐ New employer ☐ Self employed
. MEDICAL TREATMENT F	ore taxes) per pay period? FOR THIS INJURY OR ILLNESS	How often are you paid?
		ceived (skip to question F-5)
2. Were you treated on site?		
☐ Doctor's office	The state of the s	none received Emergency Room Hospital Stay over 24 hours
,		
4. Are you still being treated for	this injury/illness?	Phone Number: ()
	of the doctor(s) treating you for this injury/illness:	
One and name and address (	( ) January miles of	
One the hame and address (		
-	of the same hody part or a similar illnoss?	Priorie Number: ()
5. Do you remember having and If yes, were you treated by a	other injury to the same body part or a similar illness? doctor? Yes No If yes, provide the names	Yes No
5. Do you remember having and If yes, were you treated by a	doctor? Yes No If yes, provide the names	Yes No
5. Do you remember having and If yes, were you treated by a you and COMPLETE AND F  6. Was the previous injury/illnes	doctor? Yes No If yes, provide the names  ILE FORM C-3.3 TOGETHER WITH THIS FORM:  s work related? Yes No	Yes No and addresses of the doctor(s) who treated
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5. Do you remember having and If yes, were you treated by a you and COMPLETE AND F  6. Was the previous injury/illnes If yes, were you working for the am hereby making a claim for benand accurate to the best of my know Any person who knowingly and will be presented to, or by an material fact, SHALL BE GUILTY ployee's Signature:  behalf of Employee:  In individual may sign on behalf of the elertify to the best of my knowledge, interes asserted above have evidentiary	doctor? Yes No If yes, provide the names FILE FORM C-3.3 TOGETHER WITH THIS FORM:  s work related? Yes No he same employer that you work for now? Yes hefits under the Workers' Compensation Law. My signature wiedge and belief.  with INTENT TO DEFRAUD presents, causes to be present insurer, or self-insurer, any information containing any FAY OF A CRIME and subject to substantial FINES AND IMPRISE Print Name:  Print Name:  Print Name:  mployee only if he or she is legally authorized to do so and the emptormation and belief, formed after an inquiry reasonable under the support, or are likely to have evidentiary support after a reasonal.	No affirms that the information I am providing is true affirms that th
5. Do you remember having and If yes, were you treated by a you and COMPLETE AND F  6. Was the previous injury/illnes If yes, were you working for the and accurate to the best of my know Any person who knowingly and will be presented to, or by an material fact, SHALL BE GUILTY ployee's Signature:  behalf of Employee:  in individual may sign on behalf of the eartify to the best of my knowledge, in the sasserted above have evidentiary mature of Attorney/Representative (if a	s work related? Yes No If yes, provide the names selle FORM C-3.3 TOGETHER WITH THIS FORM:  s work related? Yes No he same employer that you work for now? Yes refits under the Workers' Compensation Law. My signature wiedge and belief.  with INTENT TO DEFRAUD presents, causes to be present insurer, or self-insurer, any information containing any FAY OF A CRIME and subject to substantial FINES AND IMPRISE Print Name:  Print Name:	No affirms that the information I am providing is true ted, or prepares with knowledge or belief that it ALSE MATERIAL STATEMENT or conceals any ONMENT.  Date:/

## STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

## PRACTITIONER'S REPORT OF INDEPENDENT MEDICAL EXAMINATION

A copy of each report of Independent Medical Examination shall be submitted on the same day and in the same manner to the Workers' C cl

THIS EXAMINATION WAS REQUESTED BY:  WCB CASE NO. CARRIER CASE NO. (IF KNOWN) DATE OF INJURY S  INJURED PERSON (First Name) (Middle Initial) (Last Name) ADDRESS (Included Name)  EMPLOYER  INSURANCE CARRIER  IF EXAMINER CONDUCTED THIS EXAMINATION AS AN EMPLOYEE OF AN IME COMPANY, OR UNDER CONTRACTOR OF IME COMPANY.  Results of Examination (continue on reverse or attach add	CT OR ARRANGEMENT WITH AN IME COMPANY, STATE NAME /
INJURED PERSON  (First Name) (Middle Initial) (Last Name) ADDRESS (Included Person)  EMPLOYER  INSURANCE CARRIER  F EXAMINER CONDUCTED THIS EXAMINATION AS AN EMPLOYEE OF AN IME COMPANY, OR UNDER CONTRANORKERS' COMPENSATION BOARD REGISTRATION NUMBER OF IME COMPANY.	Apt. No.)  CT OR ARRANGEMENT WITH AN IME COMPANY, STATE NAME A
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Results of Examination (continue on reverse or attach add	tional sheets, if necessary)
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ov certify that this report is a full and truthful representation of my preferaional and an experience of the contract of the	with request to the elements
by certify that this report is a full and truthful representation of my professional opinion	with respect to the claimant's condition.
Practitioner's Name Practitioner's Sign	ature Date
Practitioner's Address	IME Authorization No.
PIACTITIONER EXAMINING OR EVALUATING A CLAIMANT UNDER THE MORKERS COMPENSATION	IME Authorization No.

NO PRACTITIONER EXAMINING OR EVALUATING A CLAIMANT UNDER THE WORKERS' COMPENSATION LAW NOR ANY SUPERVISING AUTHORITY OR PROPRIETOR NOR INSURANCE CARRIER OR EMPLOYER MAY CAUSE, DIRECT OR ENCOURAGE A REPORT TO BE SUBMITTED AS EVIDENCE IN WORKERS' COMPENSATION CLAIM ADJUDICATION WHICH DIFFERS SUBSTANTIALLY FROM THE PROFESSIONAL OPINION OF THE EXAMINING PRACTITIONER. SUCH AN ACTION SHALL BE CONSIDERED WITHIN THE JURISDICTION OF THE WORKERS' COMPENSATION FRAUD INSPECTOR GENERAL AND MAY BE REFERRED AS A FRAUDULENT PRACTICE.