UNITED FEDERATION OF TEACHERS
SAFETY AND HEALTH DEPARTMENT

FACT SHEET FOR REPORTING AND FIILING FOR WORKERS COMPENSATION BENEFITS

If you are a Paraprofessional, a School Nurse or an Occupational/Physical Therapist it is important that (when you have an accident, incident, injury or assault) you file for workers' compensation. **Reporting the accident or incident to the administration does not meet the requirements for filing for Workers Compensation.**

You do not have to miss any days from work in order to file. Filing protects your short and long term benefits **that you will not get if** you do not follow the procedure. Filing for Workers' Compensation is often frustrating and many times our members do not want to bother. This is a mistake!

The Union has devoted resources to assist you with the process. We have a dedicated telephone help line for Workers' Compensation and we have trained and supportive staff that can discuss your situation with you and walk you through the process.

School Forms
If you are injured, please be sure that the following internal school forms have been completed:

- **Comprehensive Injury Report** (Complete this as soon as possible)
- **WCD-23 Employee s Notice of Injury**
- **OP 198 Application for Excuse of Absence for Personal Illness** (Completed with your doctor and/or submit doctor's note to get first 5 days reimbursed to sick bank)
- *** Leave of Absence form** (This is needed only after using all sick days, this will protect seniority and keep medical benefits active.)

The following **Workers Comp forms** must also be filed:

- **C-2** (You DO NOT fill out or sign, this is form is completed by the school. Double check to be sure school secretary has filed this form.
- **C-3** (Call UFT to get a copy of this form)
- **C-4** (Your Workers' Comp doctor has this form in his/her office. Double check to be sure doctor's office has filed this form.)
- **C-257** (Optional: Out of Pocket Reimbursement form.)

If you need have any questions or if you need a referral to a Workers' Comp doctor or attorney, we can be contacted at the UFT Health & Safety Department Workers' Comp Para Project: (212) 510-6460. Please call, we are here to assist you.
As a reminder, it is always important to keep copies of all your correspondence and forms as well as telephone contacts and doctors visits. Also, complete and send the forms out as soon as possible because of time limits. The sooner the forms are completed and sent out the sooner your Workers' Comp case can be processed.

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 U.I. EMPLOYER REG. NO.	(g) FEIN - if U.I 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.)

ACCIDENT

4. (a) ADDRESS WHERE ACCIDENT OCCURRED	(b) COUNTY	(c)WAS ACCIDENT ON EMPLOYER'S PREMISES? ☐ Yes ☐ 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? ☐ Yes ☐ No
h h : m m AM PM	h h : m m AM PM		m m d d y y	

INJURED PERSON

9. SEX	10.(a) AGE	(b) DATE OF BIRTH	11.OCCUPATION (Specific job title at which employed)	12. DATE HIRED
Male Female		m m d d y y		m m d d y 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.)						
$, .0 0	$, .0 0	Full Time Part Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun

NATURE OF INJURY

15. NATURE OF INJURY AND PART(S) OF BODY AFFECTED	16. (a) DID YOU PROVIDE MEDICAL CARE? ☐ Yes ☐ No	(b) IF YES, WHEN?

17. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ Yes ☐ No	18. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☐ Yes ☐ No
19. (a) NAME AND ADDRESS OF DOCTOR	(b) NAME AND ADDRESS OF HOSPITAL

20. (a) HAS EMPLOYEE RETURNED TO WORK? ☐ Yes ☐ No	(b) IF YES, GIVE DATE: m m d d y y	(c) AT WHAT WEEKLY WAGE? $, .0 0

NOTE: FORM C-11 MUST BE FILED EACH TIME THERE IS A CHANGE IN EMPLOYMENT STATUS

CAUSE OF ACCIDENT

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.

FATAL CASES

24. (a) DATE OF DEATH	(b) NAME AND ADDRESS OF NEAREST RELATIVE	(c) RELATIONSHIP
m m d d y y		

PREPARATION

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.
m m d d y y	m m d d y y	

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

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

ALBANY 12241 - 100 Broadway, Menands. (518) 474-6674 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. (607) 721-8356 For all accidents in following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins.
BUFFALO 14202 - Statler Towers, 107 Delaware Ave. (716) 842-2166 For all accidents in following counties: Cattaraugus, Chautauqua, Erie, Niagara.
ROCHESTER 14614 - 130 Main Street West. (585) 238-8300 For all accidents in following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates.
SYRACUSE 13203 - 935 James Street. (315) 423-2932 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 29017, Brooklyn, NY 11202-9017. NYC (800) 877-1373 Hemp. (516) 560-7700 Haup. (631) 952-6000 Peek. (914) 788-5775 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.

WCD-23(R84)

THE CITY OF NEW YORK

EMPLOYEE'S NOTICE OF INJURY
(PURSUANT TO 818 OF WORKERS' COMPENSATION LAW)
FORWARD TO: LAW DEPARTMENT, WORKERS' COMPENSATION DIVISION
350 JAY STREET, BROOKLYN, NY 11201-9TH FLOOR

(TOGETHER WITH C-2 WHEN POSSIBLE)

ANSWER ALL QUESTIONS FULLY. THIS IS YOUR NOTICE TO YOUR EMPLOYER TO INJURY ON THE JOB. PRINT OR WRITE LEGIBLEY.

1. Full name of injured person _____
(First) (Middle) (Last)
2. Address _____

Home Tel. No._____ Business Tel. No._____

Employee's S.S. No._____ Date of Birth_____

3. Name of Employeer CITY OF NEW YORK DEPARTMENT OF_____

4. Date of Accident_____Hour_____AM_____PM_____

5. Exact location where accident happened_____

_____

6. How did accident happen? (describe fully)_____

_____

_____

_____

7. Nature and extent of injury _____

_____

_____

8. Did you inform your supervisor of this accident?_____Date_____

9. Names and address of witness_____

_____

Dated_____

Sign Here_____

THIS IS NOT A CLAIM FORM. A CLAIM FORM MAY BE SECURED AT ANY OFFICE OF THE STATE WORKERS' COMPENSATION BOARD.