

State of New York - Workers' Compensation Board
First Report of Injury
Report Type (MTC) AU-Acquired/Unallocated

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Employee Name Jane Smith

WCB Case Number (JCN) 55555555 **Date of Injury** 01/01/2020

Claim Administrator Claim Number 555 **Maintenance Type Code Date** 01/22/2022

Claim Type N - Notification of an Incident Only **WCB Received Date** 01/22/2022

Agreement to Compensate _____

INSURER INFORMATION

Insurer Name WCB Test Insurer **FEIN** xxxxx3945

Insurer Type I - Insurer **Insurer ID** W143945

CLAIM ADMINISTRATOR INFORMATION

Name WCB Test Insurer

Info/Attn _____

Address 328 State St.

City Schenectady **State** NY

Postal Code 12305 **Country** _____

FEIN xxxxx3945 **Claim Admin ID** W143945

Late Reason _____

Claim Representative Name David Smith

Claim Representative Business Phone Number 518-555-0234

Claim Representative E-mail Address david@fcs.com

EMPLOYEE INFORMATION

First Name Jane **Middle Name/Initial** _____
Last Name Smith **Suffix** _____
Mailing Address 328 State St. _____
City Schenectady **State** NY
Postal Code 12305 **Country** _____
Phone Number 5185550234 **Gender** M - Male
Date of Birth 01/02/1963 **Date of Hire** 04/01/2019
Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx4444
Occupation Description Programmer
Employee Email Address JSmith@Fake.com

CLAIM INFORMATION

Time of injury 18:00 **Date Employer Had Knowledge of the Injury** 01/01/2020
Employment Status 1 - Regular/Full-time Employee **Date Claim Administrator Had Knowledge of the Injury** 01/01/2020
Wage Period 01 - Weekly **Initial Date Employer Had Knowledge of Date of Disability** _____
Estimated Wage \$1,050.00 **Current Date Employer had Knowledge of Current Date of Disability** _____
Work Week Type S - Standard Work Week **Number of Days Worked Per Week** 5
Date of Denial Rescission _____ **Work Days Scheduled** (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes **Employer Paid Salary in Lieu of Compensation** _____
Death Result of Injury _____ **Date of Death** _____ **Number of Dependents** _____
Nature of Injury 07 - Concussion
Part of Body _____

Part of Body Injured Location	Part of Body Injured	Part of Body Injured Fingers/Toes Location
	11 - Skull	
	15 - Nose	
B - Bilateral	35 - Hand	
L - Left	56 - Foot	
R - Right	38 - Shoulder(s)	
B - Bilateral	53 - Knee	
	12 - Brain	
	10 - Multiple Head Injury	
L - Left	36 - Finger(s) other than thumb	3 - Ring Finger or 3rd Toe
B - Bilateral	57 - Toes	2 - Middle Finger or 2nd Toe

Cause of Injury 30 - Fall, Slip or Trip Injury - Slip, or Trip, Did Not Fall

Type of Loss 02 - Occupational Disease

Accident/Injury Description

This is the accident description where I can type. This is the accident description where I can type. This is the accident description where I can type. This is the accident description where I can type. This is the accident description where I can type. This is the accident description where I can type. This is the accident description where I can type. This is the accident description where I can type. This is the accident description where I can type. This is the accident description where I can type. This is the accident description where I can type.

WORK STATUS

Initial Date Last Day Worked _____

Initial RTW Type Code _____

Initial Date Disability Began _____

Initial RTW Physical Restrictions _____

Initial RTW Date _____

Initial RTW With Same Employer _____

Latest RTW Type Code _____

Latest RTW Physical Restrictions _____

Latest RTW/Status Date _____

Latest RTW With Same Employer _____

Current Date Disability Began _____

Current Date Last Day Worked _____

First Day of Disability After the Waiting Period _____

ACCIDENT LOCATION AND WITNESSES

Premises E - Employer
Organization Name _____
Street _____ **State** _____
City _____ **Postal Code** _____
County/Parish Unknown **Country** _____
Location Narrative Unknown
Witnesses James Halpert **Business Phone Number** 5185550234

MEDICAL TREATMENT

Initial Treatment 3 - Emergency Evaluation, Diagnostic Testing, and Medical Procedures
Managed Care Org. _____
Managed Care Org. ID _____

EMPLOYER INFORMATION

Name Really Great Programmers Inc. **Employer FEIN** xxxxx4234
Industry Code 236116 **UI Number** 16-10000
Manual Classification 5645 - Carpentry-Detached One Or Two-Family Dwellings
Info/Attn _____
Mailing Address 328 State St.
City Schenectady **State** NY
Postal Code 12305 **Country** _____
Physical Addr 328 State St.
City Schenectady **State** NY
Postal Code 12305 **Country** _____
Contact Name James Halpert
Contact Business Phone Number 5185550234

INSURED INFORMATION

Insured Name Really Great Programmers Inc.

Insured FEIN xxxxx4234

Insured Type I - Insured

Insured Location ID _____

Policy Number ID 23423432

Policy Effective Date 01/01/2020

Policy Expiration Date _____