

State of New York - Workers' Compensation Board
First Report of Injury
Report Type (MTC) 00-Original

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Employee Name John T Doe, Scenario 1-2
WCB Case Number (JCN) _____ Date of Injury 08/01/2012
Claim Administrator Claim Number TW0892356 Maintenance Type Code Date 09/12/2012
Claim Type M - Medical Only WCB Received Date filled by WCB

INSURER INFORMATION

Insurer Name All American Insurance Company FEIN xxxxx6789
Insurer Type I - Insurer Insurer ID W123456

CLAIM ADMINISTRATOR INFORMATION

Name All American Insurance Company
Info/Attn _____
Address PO Box 12345
City Latham State NY
Postal Code 12110 Country _____
FEIN xxxxx6789 Claim Admin ID T123456
Late Reason L2 - Late Notification, Employer

EMPLOYEE INFORMATION

First Name John Middle Name/Initial T
Last Name Doe, Scenario 1-2 Suffix _____
Mailing Address 123 Nott Street
City Schenectady State NY
Postal Code 12308 Country _____
Phone Number 5185550234 Gender M - Male
Date of Birth 11/01/1977 Date of Hire 04/01/2001
Employee ID Type A - Employee ID Assigned by Jurisdiction Employee ID 771101JDOE
Occupation Description Carpenter

CLAIM INFORMATION

Time of injury 13:00 **Date Employer Had Knowledge of the Injury** 08/01/2012
Employment Status 01 - Full Time **Date Claim Administrator Had Knowledge of the Injury** 08/03/2012
Wage Period 01 - Weekly **Date Employer Had Knowledge of Date of Disability** 08/01/2012
Estimated Wage \$26.25 **Number of Days Worked Per Week** 5
Work Week Type S - Standard Work Week **Work Days Scheduled** (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S
N	S	S	S	S	S	N

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes **Employer Paid Salary in Lieu of Compensation** No
Death Result of Injury _____ **Date of Death** _____ **Number of Dependents** _____
Nature of Injury 49 - Sprain
Part of Body 55 - Ankle
Cause of Injury 26 - Fall, Slip or Trip from ladder
Type of Loss 01 - Trauma

Accident/Injury Description

Mr. Doe was descending a ladder and missed the last step and injured RT ankle

WORK STATUS

Initial Date Last Day Worked _____ **Return To Work Type** _____
Initial Date Disability Began _____ **Physical Restrictions** _____
Initial Return to Work Date _____ **Return To Work Same Employer** _____

ACCIDENT LOCATION AND WITNESSES

Premises E - Employer
Organization Name _____
Street 1234 Broadway **State** NY
City Albany **Postal Code** 12204
County/Parish Albany **Country** _____

Location Narrative

Witnesses

Jane Smith

Business Phone Number

5184029394

MEDICAL TREATMENT

Initial Treatment 3 - Emergency Room

Managed Care Org. _____

Managed Care Org. ID _____

EMPLOYER INFORMATION

Name Great Roofing Inc. Employer FEIN xxxxx8765

Industry Code 236116 UI Number 16-10000

Manual Classification 5645 - Carpentry

Info/Attn _____

Mailing Address PO Box 1587

City Albany State NY

Postal Code 12241 Country _____

Physical Addr 1541 Circular St.

City Albany State NY

Postal Code 12241 Country _____

Contact Name Jane Smith

Contact Business Phone Number 5184029394

INSURED INFORMATION

Insured Name Great Roofing Inc. Insured FEIN xxxxx8765

Insured Type I - Insured Insured Location ID JS51

Policy Number ID COA65432

Policy Effective Date 01/01/2012 Policy Expiration Date 01/01/2013