

State of New York - Workers' Compensation Board
First Report of Injury
Report Type (MTC) UR-Upon Request

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Employee Name John T Doe, Scenario 9-4
WCB Case Number (JCN) 50009999 Date of Injury 02/02/2004
Claim Administrator Claim Number TW0892356 Maintenance Type Code Date 11/19/2012
Claim Type I - Indemnity 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 _____

FULL DENIAL REASONS

Full Denial Effective Date _____
Full Denial Reason _____
Denial Reason Narrative _____

EMPLOYEE INFORMATION

First Name John **Middle Name/Initial** T
Last Name Doe, Scenario 9-4 **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 S - Employee Social Security Number **Employee ID** xxxxx6745
Occupation Description Carpenter

CLAIM INFORMATION

Time of injury 13:00 **Date Employer Had Knowledge of the Injury** 02/02/2004
Employment Status 01 - Full Time **Date Claim Administrator Had Knowledge of the Injury** 02/02/2004
Wage Period 01 - Weekly **Date Employer Had Knowledge of Date of Disability** 02/02/2004
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 28 - Fracture
Part of Body 42 - Low Back Area
Cause of Injury 26 - Fall, Slip or Trip from ladder
Type of Loss 01 - Trauma

Accident/Injury Description

Mr. Doe was stepping off a roof and lost his footing and fell from a ladder injuring his back

WORK STATUS

Initial Date Last Day Worked 02/03/2004 **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 **Business Phone Number**

Jane Smith 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 01/01/2004

Policy Expiration Date 01/01/2005

SAMPLE