

PO Box 5205, Binghamton, NY 13902-5205

www.wcb.ny.gov

## State of New York - Workers' Compensation Board REPORT OF WORK-RELATED INJURY OR OCCUPATIONAL DISEASE

This form is to be filed with the Workers' Compensation Board within 10 days of a work-related injury or illness. A copy of this report should be provided to your insurance carrier. No hearing will be scheduled at the Board in response to this report of injury.

at the Board in response to this	<u> </u>				
EMPLOYER'S NAME AND MAILING ADDRESS		INSURANCE CARRIER'S NAME AND MAILING ADDRESS			
FILING ENTITY: Employer Carrier Other (If "Other", give name and a			CARRIER ID NUMBER	CARRIER CASE NUMBER	
			W-		
			WC POLICY NUMBER	EFFECTIVE DATE OF POLICY	
			WC POLICT NOWIDER	EFFECTIVE DATE OF POLICE	
INJURED EMPLOYEE (First Name, Middle Initial, Last Name) EMPL			S ADDRESS (Street No. & Nar	ne, Apt No., City, State & Zip Code)	
UNION NAME & LOCAL NUMBER					
EMPLOYEE'S SOCIAL SECURITY NUMBER DATE OF BIRTH		TELEPHONE NUMBER		GENDER	
SPECIFIC DETAILS AS TO OCCURRENCE OF INJURY AND PART(S) OF BODY AFFECTED					
SI EGINE DETAILS AS TO OCCORRENCE OF INSORT AND FART(S) OF BODT AT LETED					
ADDRESS WHERE INJURY OCCURRED			DATE OF INJURY	TIME OF INJURY	
			DATE SUPERVISOR FIRST KNEW OF INJURY		
WAS MEDICAL CARE PROVIDED? YES NO IF YES, BY WHOM?					
DATE(S) MEDICAL CARE PROVIDED:					
IS THIS A DEATH CASE?	NO				
]					
HAS EMPLOYEE RETURNED TO WORK?					
Prepared by		Official Titl	e		
Date of this Report			Number & Extension		
		repriorie			
ADR-1 ADR-'	I AD	<b>R-1</b>	ADR-1	ADR-1	
Prescribed by Chair	SEE FILINO	<b>G INSTR</b>		HE WORKERS' COMPENSATION BOARD	
(6-22) Workers' Compensation Board State of New York	ON	REVERS	E	MPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.	

## **FILING INSTRUCTIONS**

Please note that the ADR-1 Report of Injury form must be submitted to the Workers' Compensation Board within 10 days of a work related injury or illness, as required by 12 NYCRR § 314.2(d)(5).

The ADR-2 Final Disposition of Claim form must be filed with the Workers' Compensation Board's local district office within 30 days of the final resolution of a claim through settlement, mediation, or arbitration, as required by 12 NYCRR § 314.7(a).

Failure to file the prescribed ADR forms with the Workers' Compensation Board in a timely manner may result in revocation of the parties' authorization to participate in the Alternative Dispute Resolution Pilot Program.