STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

PROOF OF DEATH

(By Physician Last in Attendance on Deceased)

This report must be signed by the physician last in attendance on the deceased in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases. In hospital cases it may be signed by a licensed physician who is a member of the attending staff of the hospital to whom treatment of the case was assigned. File the signed original of this report directly with (1) CHAIR, WORKERS' COMPENSATION BOARD at the centralized address listed below and file a signed copy with (2) the INSURANCE CARRIER, if known, or the EMPLOYER.

ANSWER ALL QUESTIONS FULLY-- TYPEWRITER/COMPUTER PREPARATION IS STRONGLY RECOMMENDED

1. WCB Case Number (If Known)	2. Carrier Case Number (If Known)	3.Date of Accident or Injury and Time		4. Address Where Accident or Injury Occurred

	NAME		ADDRESS	
5. DECEASED PERSON		Date of Birth		Soc. Sec. Number
6. EMPLOYER *				
7. INSURANCE CARRIER				
8. HOSPITAL (If any)				
9. NEAREST RELATIVE		Relationship		

* If claim is made that death resulted from injury sustained in the performance of assigned duty as a Volunteer Firefighter or Volunteer Ambulance Worker show as EMPLOYER the city, town, village or district or ambulance company against which claim is made and enter "X" here: VF/VAW

10. (a) Date of death _____ (b) Place of death (Give street number, city, state): _____

11. Decedent's marital status at time of death (Single, married, widowed, divorced): _____

12. (a) How long have you been medical advisor of deceased? _____ (b) Date of your first visit: _____

(c) Date of last visit: _____ (d) Was deceased attended by any other physician during last illness? _____

If so, give name and address of other _____

_____

13. State in patient's own words how the accident or injury occurred: _____

_____

_____

_____

14. Give complete and accurate description of nature and extent of injury, as you found it and subsequent examinations: _____

_____

_____

15. State the direct cause of death _____

(a) In your opinion was the accident or injury as above described a cause either directly or indirectly of the death? _____

15. (b) Describe contributory causes, if any: _____

_____

16. Was coroner's inquest held? _____ If so, give coroner's name and address: _____

_____

I state that I am a physician duly licensed to practice medicine in the State of New York.

W.C.B. Rating Code _____ _____
(Written Signature of Attending Physician)

W.C.B. Authorization Number _____ Address _____

Dated _____ _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Reports should be sent directly to the Workers' Compensation Board at the address listed below:

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Statewide Fax Line: 877-533-0337