STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

VOLUNTEER'S NOTIFICATION OF EXECUTIVE OFFICER OF FIRE/AMBULANCE COMPANY OF SIGNIFICANT RISK OF TRANSMISSION OF HIV

PER VFBL/VAWBL SECTION 11-c(1)

Notice to the Executive Officer of a Fire Company/Ambulance Company that a volunteer firefighter/volunteer ambulance worker has been exposed to a significant risk of transmission of the Human Immunodeficiency Virus (HIV) while performing services in the line of duty.

VFBL/VAWBL Section 11-c(1) requires the Executive Officer of a Volunteer Fire/Ambulance Company to authorize a volunteer firefighter/volunteer ambulance worker to obtain an appropriate medical examination to determine if such volunteer firefighter/ambulance worker has been exposed to or infected with HIV within 8 hours of receipt of the notice of an incident that has created an exposure risk to the volunteer firefighter/ambulance worker to HIV while performing services in the line of duty.

INSTRUCTIONS TO VOLUNTEER: PRESENT THIS FORM TO THE EXECUTIVE OFFICER OF FIRE/AMBULANCE COMPANY. SEND A COPY TO THE WORKERS' COMPENSATION BOARD (SEE MAILING ADDRESS AND PERSONAL PRIVACY PROTECTION NOTIFICATION ON REVERSE).

NAME OF VOLUNTEER FIREFIGHTER/AMBULANCE WORKER	DATE OF BIRTH	SOCIAL SECURITY NO.	TELEPHONE NUMBER	SEX

RESIDENTIAL ADDRESS	MAILING ADDRESS, IF DIFFERENT

NAME AND ADDRESS OF FIRE/AMBULANCE COMPANY	TELEPHONE NUMBER

DATE AND TIME OF EXPOSURE	SPECIFIC PARTS OF BODY EXPOSED

ADDRESS WHERE EXPOSURE OCCURRED	WITNESSES, IF ANY

HOW DID EXPOSURE OCCUR?

Signature of Volunteer Firefighter/Ambulance Worker	Date Signed	Time of Submission to Executive Officer

FOR USE BY EXECUTIVE OFFICER OF FIRE/AMBULANCE COMPANY

The volunteer firefighter/ambulance worker named above is authorized to obtain an appropriate medical examination to determine if he/she has been exposed to or infected with the human immunodeficiency virus (HIV).

Name of Executive Officer	Signature of Executive Officer	Date	Time of Approval

www.wcb.ny.gov
Statewide Fax Line: 877-533-0337

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

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

Customer Service Toll-Free Line: 877-632-4996 **Statewide Fax Line: 877-533-0337**

Notification Pursuant to the New York Personal Privacy Protection Law
(Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a).

The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.