

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

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

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** 09/17/2012

Agreement to Compensate L - With Liability

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

Date of Denial Rescission _____

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