State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) AU-Acquired/Unallocated

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 9-5

WCB Case Number (JCN) 50009999 **Date of Injury** 02/02/2004

Claim Administrator Claim Number A678B1234 **Maintenance Type Code Date** 11/19/2012

Claim Type I - Indemnity **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 Great Lakes Claims

Info/Attn

Address PO Box 54321

City Great Lakes **State** MI

Postal Code 48201 **Country**

FEIN xxxxx9145 **Claim Admin ID** T123456

Late Reason

EMPLOYEE INFORMATION

First Name John **Middle Name/Initial** T

Last Name Doe, Scenario 9-5 **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

Employment Status 01 - Full Time

Wage Period 01 - Weekly

Estimated Wage $26.25

Work Week Type S - Standard Work Week

Date Employer Had Knowledge of the Injury 02/02/2004

Date Claim Administrator Had Knowledge of the Injury 02/02/2004

Date Employer Had Knowledge of Date of Disability 02/02/2004

Number of Days Worked Per Week 5

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 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

Initial Date Disability Began

Initial Return to Work Date

Return To Work Type

Physical Restrictions

Return To Work Same Employer

ACCIDENT LOCATION AND WITNESSES

Premises E - Employer

Organization Name

Street 1234 Broadway

City Albany

County/Parish Albany

State NY

Postal Code 12204

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