WARREN COUNTY SELF-INSURANCE DEPARTMENT
1340 State Route 9 * Lake George NY 12845 * Phone 518-761-6528 * Fax 518-761-6249
email: warrencountyinsurance@warrencountyny.gov

Procedure for Reporting Workers' Compensation Injury

For Warren County Departments ONLY

Employee Responsibilities:

1. Complete "Employee Claim" (Form C-3.0) – 2 pages
2. Complete "Supplement to C3 form" – 1 page
3. Complete "Limited Release of Health Information" (Form C-3.3) – 1 page
4. Complete "Authorization to Obtain Information" (WC Form 5) – 1 page

- ❖ The 4 forms above should be provided to your supervisor immediately.

If your injury requires medical care:

This packet contains forms that you will need to take with you to the treating provider & pharmacy.

Take a copy of "Workers' Compensation Encounter Form" (WC Form 10) with you to each doctor visit.

Tell your doctor or hospital to send all bills to the following address. Be sure to mark the date of injury clearly on all correspondence.

Warren County Self-Insurance, 1340 State Route 9, Lake George NY 12845

If you require pharmaceuticals for this injury, take the "Temporary Prescription Form" page with you to the pharmacy.

Provide your supervisor with proper medical documentation if time away from work is recommended.

If your injury requires medical treatment, you will receive a packet with claim information in the mail.

Supervisor Responsibilities:

- ➢ If the injury is serious or the employee is expected to be out of work more than a day, call Self-Insurance immediately to alert them to the claim. Then follow up with the paper work as soon as possible.
- ➢ Confirm that the employee has completed and given you the forms:

  "Employee Claim" (Form C-3.0) – 2 pages

  "Supplement to C3 form" – 1 page

  "Limited Release of Health Information" (Form C-3.3) – 1 page

  "Authorization to Obtain Information" (WC Form 5) – 1 page
- ➢ Advise and confirm that the employee has retained forms:

"Claimant Information Packet" – 2 pages

"Workers' Compensation Encounter Form" – 1 page

The list of pharmacies – 1 page

- Complete the Employer Instructions section on the "Temporary Prescription Form" page and return that page to the employee.
- Complete Form C-2F – 3 pages
- If there were witness(es) to the accident, provide each witness with the form "Accident Investigation Witness Statement "
- Complete Form "Supervisor's Report of Accident Investigation, Supplement to C2 form"
- Forward completed Employee forms (4), completed Supervisors forms (2) and any Witness Statements to Self-Insurance.
- Notify Self-Insurance when employee returns to work OR if the employee's condition changes.

Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: ____/____/____

3. Mailing address: _____ (Number and Street/PO Box / City / State / Zip Code)

4. Social Security Number: ___-___-___ 5. Phone Number: (____)_____ 6. Gender: ☐ Male ☐ Female

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

_____

_____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

_____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

_____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

_____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

_____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

_____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

_____

_____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

_____

_____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

YOUR NAME: _____ DATE OF INJURY/ILLNESS: ____/____/____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____

If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

_____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

_____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.

2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty

3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed

4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)

2. Were you treated on site? ☐ Yes ☐ No

3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
Name and address where you were first treated: _____

_____ Phone Number: (____)_____

4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
Give the name and address of the doctor(s) treating you for this injury/illness: _____

_____ Phone Number: (____)_____

5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**

_____

_____

_____

6. Was the previous injury/illness work related? ☐ Yes ☐ No
If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

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.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____

WARREN COUNTY SELF-INSURANCE DEPARTMENT

1340 State Route 9 * Lake George NY 12845 * Phone 518-761-6528 * Fax 518-761-6249

Employee's Report of Incident Supplement to C3 Form

(To be completed immediately. This forms does not replace Worker's Compensation forms. Established procedures for Worker's Compensation reporting must continue to be followed.)

Personal Information

Name	
Time in current position	

Accident Information

Date of Accident		Time of day that you began work on day of accident	
Weather Conditions at Time of Accident			

How Could the Accident Have Been Prevented?

Protective Equipment in Use at the time of the Accident:

Signed:

Employee Name		Date	
Supervisor		Date	
Department Head		Date	

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

WCB Case No. *(if you know it)*:_____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:_____ 2. Social Security Number:_____-_____-_____
3. Mailing Address: _____
4. Date of Birth: _____/_____/_____ 5. Date of the current injury/illness: _____/_____/_____
6. Current injury/illness, including all body parts injured:_____
   _____
7. Your legal representative's name and address (if any):_____
   _____

☐ *Check here if you allow your health care provider(s) to release* ***mental health care*** *information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:_____ 2. Phone Number: (_____)_____
3. Mailing Address: _____
4. Other provider (if any):_____ 5. Phone Number: (_____)_____
6. Mailing Address:_____

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____
Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

_____
Your name Relationship to Claimant Signature (ink only -- use blue ballpoint pen, if possible.) Date

Versión en español al reverso de la forma.

AUTHORIZATION TO OBTAIN INFORMATION

AUTHORIZATION FOR THE USE AND DISCLOSURE
OF INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize Warren County Self-Insurance to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Person(s) / organizations authorized to use or disclose the information:

   Any medical facility that has treated me in the past.

2. Person(s) / organization to whom the requested use or disclosure may be made:

   Warren County Self-Insurance and/or its agents.

3. Specific description of information that may be used or disclosed:

   Copies of medical records including, but not limited to, patient questionnaires, patient intake sheets, referral forms, patient history forms, office notes, reports, charts, x-ray or other films, etc., and/or copies of hospital and medical records relating to services rendered to me for the following medical condition(s):

   Any condition except those excluded below.

   Excluding (1) any and all confidential HIV and AIDS related information protected under Article 27-F of the New York Public Health Law and (2) any and all confidential mental health records protected under Section33.13 of the New York Mental Hygiene Law.

4. Purpose of the requested use or disclosure:

   For the use in a pending Workers' Compensation claim brought by me.

5. I understand that I may revoke this authorization at any time by giving written notice to the person / organization that is providing the information I no longer want to be used or disclosed, except to the extent that action has already been taken in reliance on this authorization.

6. I understand that the medical provider may not condition the provision of health care services on whether I sign this authorization.

7. This authorization expires upon the final closure of the Workers' Compensation claim brought by the individual.

8. Photocopies of this authorization should be accepted as original.

_____ _____ _____

Signature of Individual Authorizing Use/Disclosure Date Printed Name of Individual

For Office Use: Date of Injury:_____ Carrier Case #_____ WCB#_____

WC Form 5

Claimant Information Packet

WARREN COUNTY SELF-INSURANCE DEPARTMENT
1340 State Route 9 * Lake George NY 12845 * Phone 518-761-6528 * Fax 518-761-6249
Email: warrencountyinsurance@warrencountyny.gov

You were injured at work. What now?

If you've suffered a workplace injury or illness, you may be eligible for workers' compensation benefits. You may have already received medical treatment. If you haven't, you should seek the medical care that is necessary.

A Worker's Responsibilities

- You must tell your employer, in writing, when, where and how you were injured. Report injuries as soon as possible but always within 30 days of the injury.
- Medical reports are necessary for your case. Advise your doctors that you have a work-related injury, and give the name of your employer. Do not pay for your care yourself or use other health insurance. Tell your doctor to file reports with the NYS Workers' Compensation Board and with Warren County Self-Insurance, your employer's insurance carrier. Ask that your doctor complete the "Workers' Compensation Encounter Form" and fax it back to Warren County Self-Insurance. This may help expedite your claim. If your case is disputed, the Workers' Compensation Board needs a medical report on your injury to begin resolving your claim.

Starting a Case

Once your employer knows of your injury, they must notify the Warren County Self-Insurance Department by filing a C-2 form. You should file an employee claim (C-3 form) reporting your injury as soon as possible. If you injured the same body part before, or had a similar illness, you must also file a Form C-3.3. You should complete the "Authorization to Obtain Information" and give it to your employer immediately.

If you haven't already filed a C-3 or C-3.3 (if necessary), there are three ways to do it.

- Complete the paper forms that your employer provided to you and give them to the employer. Additionally, you can also mail this form to the Workers' Compensation Board.
- Visit www.wcb.ny.gov to complete the form
- Call 1-866-396-8314. A Workers' Compensation Board employee will complete the form with you.

Health Care Benefits

Do not pay your doctor or hospital. Those bills are paid by the insurer unless the Workers' Compensation Board disallows your case. If your case is disputed, the providers are paid when the Workers' Compensation Board decides your case. If the Workers' Compensation Board decides against you, or if you don't pursue a case, you will have to pay the doctor or hospital.

Warren County Self-Insurance covers medically necessary drugs and equipment that your doctor prescribes. You're also entitled to carfare or necessary expenses incurred when traveling for treatment. (Get receipts for those expenses.)

Generally, you can choose any doctor authorized by the Workers' Compensation Board. You can also use occupational health clinics. Warren County participates in the ONECALL MEDICAL diagnostic radiology network, therefore if you require diagnostic radiology services (MRI, EMG, NCS, CT, Ultrasound, Bone Scan or Arthrograms) you or your physician must contact us before performing these tests. Additionally, Warren County participates in the AWPRx pharmacy benefits network. Therefore, pharmacy benefits must be obtained from a AWPRx network pharmacy.

Benefits for Lost Wages

You are entitled to a portion of your lost wages if your injury affects you in one or more ways:

1. It keeps you from work for more than seven days;
2. Part of your body is permanently disabled;
3. Your pay is reduced because you now work fewer hours or do other work.

An employer or insurer can accept your claim and begin paying your lost wage benefit promptly. Sometimes, employers and carriers dispute a claim. When that occurs, the Workers' Compensation Board strives to resolve most cases within 90 days.

You may hire an attorney or licensed representative, who can be helpful with complex or disputed claims, but it isn't required. The Workers' Compensation Board sets their fees and they will be deducted from your lost wages award. You should not pay anything directly to your attorney or licensed representative.

If your case is disputed, you may be eligible to receive short term disability benefits while the case is heard. Check with your employer about disability benefits and ask for a DB-450 claim form. If your case is accepted, you will pay back the disability benefits out of your lost wages award.

Help is Available

People sometimes need help getting back to work. An injury can also cause family or financial problems. The Workers' Compensation Board has rehabilitation counselors and social workers to help. Call (877) 632-4996 for assistance. More information is also available on the NYS Workers' Compensation Board website at: http://www.wcb.ny.gov

What's Next?

Warren County Self-Insurance will send you information and documentation if your claim is accepted or denied. When the claim is accepted, your treatment will be paid and lost wages benefits begin. If your case is challenged, the Workers' Compensation Board will notify you about resolving the case. If more information is necessary, the Workers' Compensation Board will contact you and tell you how to file it.

Important Contact Information

Workers' Compensation Board	877-632-4996
Warren County Self-Insurance	518-761-6528

Warren County Self-Insurance Department
1340 State Route 9, Lake George NY 12845
518-761-6528, Fax 761-6249, e-mail warrencountyinsurance@warrencountyny.gov

CC#_____

Workers' Compensation Encounter Form

To the Employee: Give one copy of this form to your physician/ chiropractor at each visit. (Call Self-Insurance for additional forms or duplicate this one.)

Patient Name:_____

Date of Service:_____ Date of Birth:_____

In your opinion, is the disability arising out of and in the course of employment or occupational disease? Yes No

Date of injury:_____

Is the patient losing time from work? Yes / No First day of lost time:___/___/___

Can the patient return to work? Full duty / Modified duty _____/ _____/_____

Modified duty requirements:_____

Diagnosis:_____

Prescriptions given to treat injury:_____

Treatment Plan:_____

Percentage of impairment (0-100%):_____% Temporary / Permanent

Apportionment? Yes No Pre-existing _____% Current injury_____%

Next visit:___/___/___ Time:_____ with Provider:_____

Providers Signature:_____ Date:____/____/____

Please Fax this form immediately to: 518-761-6249

The AWPRx pharmacy network is a national network that includes both national chains and local independent pharmacies. For a list of network pharmacies, please visit our website at www.awprx.com or call our customer service team for a list of network pharmacies in your area **888-700-0992.**

A&P
ACME PHARMACY
AHF PHARMACY
BARTELL DRUGS
BEL AIR PHARMACY
BIG Y PHARMACY
BI-MART PHARMACY
BROOKSHIRE BROTHERS
CITY MARKET PHARMACY
COBORNS PHARMACY
CONTINUCARE MEDICAL GROUP
COSTCO WHOLESALE
CVS PHARMACY
DIERBERGS
DISCOUNT DRUG MART
EMBLEMHEALTH SERVICES
ESSENTIA HEALTH
FAGEN PHARMACY
FARM FRESH PHARMACY
FARMACIAS PLAZA
FOOD CITY PHARMACY
FOOD LION PHARMACY
FRUTH PHARMACY
FRYS FOOD AND DRUG
GERBES PHARMACY
GIANT EAGLE PHARMACY
HAGGEN PHARMACY
HARRIS TEETER PHARMACY
HARTIG DRUG CO INC
HARVARD VANGUARD MEDICAL ASSOCIATES PHAR
HARVEYS SUPERMARKET
HEALTHPARTNERS
HEB PHARMACY
HENRY FORD MEDICAL CENTER
HY-VEE PHARMACY
KELSEY PHARMACY
KERR DRUG
KING KULLEN PHARMACY
KING SOOPERS PHARMACY
KINNEY DRUGS
KMART PHARMACY
KROGERS
LONESTAR RX
LOWELL COMMUNITY HEALTH CENTER PHARMACY
MACEYS PHARMACY
MARCS PHARMACY
MARSH DRUGS
MARSHFIELD CLINIC SPECIALTY
MARTINS PHARMACY
MEDFAST PHARMACY
MEIJER PHARMACY
NAVARRO HEALTH SERVICES
OMNICARE
OSCO PHARMACY
PARADIS SHOP N SAVE
PATHMARK PHARMACY
PATIENT FIRST
PICK N SAVE PHARMACY
POSTAL PRESCRIPTION SERVICES
PRICE CHOPPER PHARMACY
PRICE CUTTER PHARMACY
PUBLIX PHARMACY
QFC
QOL MEDS
QUICK CHEK PHARMACY
RALEYS PHARMACY
RALPHS PHARMACY
REASORS PHARMACY
RITE AID PHARMACY
RITZMAN PHARMACY
ROY HARMONS APOTHECARY
RXAMERICA
SAFEWAY PHARMACY
SAFFA INFUSION PHARMACY
SARTORIS SUPER DRUGS
SAVE MART PHARMACY
SAVON PHARMACY
SCHNUCKS PHARMACY
SHOPKO STORE
SHOPPERS PHARMACY
SHOPRITE PHARMACY
SMITHS PHARMACY
ST JOHN SPECIALTY PHARMACY
STOP AND SHOP PHARMACY
SUN MART PHARMACY
SUPER ONE
TARGET STORES
TEXAS ONCOLOGY PHARMACY
TFHC23 PHARMACY
THE PHARMACY CENTER
TIMES PHARMACY
TIMPVIEW PHARMACY
TOPS PHARMACY
UNITED MEDICAL
UNITED PHARMACY
VANGUARD ADVANCED PHARMACY SYSTEMS
VG'S PHARMACY
VILLAGE PHARMACY
VILLAGE SUPERMARKETS
VONS PHARMACY
WALDBAUMS PHARMACY
WALMART PHARMACY
WEGMANS FOOD MARKETS
WEIS PHARMACY
WELLSPRING FAMILY MEDICINE
WHITE DRUG
WINN DIXIE PHARMACY

AWPRx

The Right Med. At The Right Price. At The Right Time.

Temporary Prescription Form

Client Name: **Warren County**

1. Instructions for the **EMPLOYER**:

- Provide this form to your injured worker to have any prescription filled for a temporary **10 day supply**, and please fill out the information below:

Claimant Name: _____ **SSN:** _____
Claimant DOB: _____ **Claimant's Home Phone #:** _____
Claimant Employer: _____ **Date of Injury:** _____
Claimant Address: _____
City: _____ **State:** _____ **Zip:** _____
Employer Representative: _____ **Date:** _____

2. Instructions for the **INJURED WORKER**:

- **You, the injured worker will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work related injury/illness**

3. Instructions for the **PHARMACY**:

- Please submit workers' compensation claims to **AWPRX**
- **BIN** **610237**
- **PCN** **AWPRX**
- **Group ID** **AWPRx63**
- **ID number** **Use Social Security from the top of the form**
- Prescription(s) will fill for a **10 Day Supply**. If there is a remaining balance on the script after the **10 Day Supply** is filled, AWPRx will call back if and when the balance has been approved. If you need assistance, please call **AWPRx** at **888-700-0922**.

AWPRx office hours are Monday through Friday, 8:00AM EST to 8:00PM EST. We also have representative's on-call 24 hours/7 days a week.

FOR ALL REJECTIONS OR QUESTIONS CALL: (888)-700-0922

WARREN COUNTY SELF-INSURANCE DEPARTMENT

1340 State Route 9 * Lake George NY 12845 * Phone 518-761-6528 * Fax 518-761-6249

Accident Investigation Witness Statement (Appendix C)

Personal Information

Name of Witness	
Address	
City, State, Zip	
Phone	

Employment Information

Department		Work Site	
Occupation		Supervisor	
Date of Hire		Time in current position	

Accident Information – Injured Person's Name: _____

Date accident occurred		Time of Accident	
Location of accident		Weather Conditions at time of Accident	

In your words, give a brief description of the accident:

How did the Injury Occur?

How Could the Accident Have Been Prevented?

Signed:

Witness Name		Date	

WARREN COUNTY SELF-INSURANCE DEPARTMENT

1340 State Route 9 * Lake George NY 12845 * Phone 518-761-6528 * Fax 518-761-6249

Supervisor's Report of Accident Investigation (Appendix D)
Supplement to C2 Form

(To be completed immediately. This form does not replace Worker's Compensation forms. Established procedures for Worker's Compensation reporting must continue to be followed.)

Date of Investigation:	Investigator:
Injured Person:	

Describe the accident in detail (include physical surroundings, equipment in use)

SPECIFY THE UNSAFE ACTS AND CONDITIONS WHICH LED TO THE ACCIDENT (Please circle all that apply):

Unsafe Acts:

- Improper lifting, carrying, handling
- Improper use of tools or equipment
- Operating without authority
- Failure to wear personal protective equipment
- Failure to use safety devices
- Failure to use proper tools/equipment
- Failure to obey rules/procedures
- Failure to secure ladders
- Lack of adequate training
- Transitioning to/from ladder
- Misstep on ladder
- Over-reaching on ladder
- Using defective equipment
- Overriding safety devices
- Horseplay
- Taking shortcuts or hurrying
- Action of others
- Other: _____

Unsafe Conditions:

- Wet and/or slippery working surface
- Defective floor and/or walking area
- Congested work area
- Poor housekeeping
- Inadequate lighting
- Inadequate guards
- Inadequate design or maintenance
- Lack of available personal protective equip
- Lack of proper tools or equipment
- Defective tools or equipment
- Inadequate warning system
- Projection hazards
- Hazardous atmosphere
- Other: _____

WARREN COUNTY SELF-INSURANCE DEPARTMENT

1340 State Route 9 * Lake George NY 12845 * Phone 518-761-6528 * Fax 518-761-6249

Supervisor's Report of Accident Investigation (Appendix D) Supplement to C2 Form – Page 2

Personal Factors:

- Improper work habits
- Unaware of work hazard
- Improper motivation
- Improper attire
- Improper attitude
- Unwilling to follow work rules
- Other: _____

Was there an infraction of a Safety/Health Rule, Regulation, Procedure or Specific Instruction?

Was the Employee Properly Instructed and/or Trained (Please describe):

What corrective measures are being taken to prevent similar accidents?

Signed:

Supervisor:	Phone:	Date:
Supervisor Email address:		
Department Head:	Phone:	Date:
Department Head Email address:		

WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

Employer's First Report of Work-Related Injury/Illness

C-2F

A work-related injury or illness must be reported within 10 days (Per Section 110) of the injury/illness or be subject to a penalty. Employers are not required to submit form C-2F to the Workers' Compensation Board if the employer's insurer will be submitting the accident information electronically to the Board on the employer's behalf. If you need assistance completing this form, please contact your insurer for guidance on the best method of reporting work-related accident information. If you submit this form to the Board, please send it to P.O. Box 5205, Binghamton, NY 13902 and provide a copy to your insurer.

Employee Name _____

WCB Case Number (JCN) _____ **Date of Injury** _____

Claim Administrator Claim Number _____

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name Warren County Self-Insurance Plan **Insurer ID** W874754

Name Warren County Self-Insurance Plan

Info/Attn _____

Address 1340 State Route 9

City Lake George **State** NY

Postal Code 12845 **Country** USA

Claim Admin ID W874754

EMPLOYEE INFORMATION

First Name _____ **Middle Name/Initial** _____

Last Name _____ **Suffix** _____

Mailing Address _____

City _____ **State** _____

Postal Code _____ **Country** _____

Phone Number _____ **Date of Hire** _____

Date of Birth _____ **Gender** ☐ Male ☐ Female ☐ Unknown

Employee SSN _____

Occupation Description _____

CLAIM INFORMATION

Time of Injury _____ **Date Employer Had Knowledge of the Injury** _____

Employment Status _____ **Date Employer Had Knowledge of Date of Disability** _____

Estimated Weekly Wage _____ **Number of Days Worked Per Week** _____

EMPLOYEE INJURY

Full Wages Paid for Date of Injury ☐Yes ☐No **Employer Paid Salary in Lieu of Compensation** ☐Yes ☐No

Initial Treatment ☐No Medical Treatment ☐Minor On-Site Treatment By Employer ☐Minor Clinic/Hospital Treatment
☐Emergency Evaluation ☐Hospitalization Greater Than 24 Hours ☐Future Major Medical/Lost Time Anticipated

Death Result of Injury ☐Yes ☐No ☐Unknown **Date of Death** _____ **Number of Dependents** _____

Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc) _____

Part of Body (i.e. left arm, right foot, head, multiple, etc) _____

Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc) _____

Accident/Injury Description (see instructions)

WORK STATUS

Initial Date Last Day Worked _____ **Return To Work Type** ☐Actual ☐Released

Initial Date Disability Began _____ **Physical Restrictions** ☐Yes ☐No

Initial Return to Work Date _____ **Return To Work Same Employer** ☐Yes ☐No

ACCIDENT LOCATION AND WITNESSES

Premises (see instructions) ☐Employer ☐Lessee ☐Other

Organization Name _____

Street _____ **State** _____

City _____ **Postal Code** _____

County _____ **Country** _____

Location Narrative _____

Witnesses **Business Phone Number**

_____ _____

_____ _____

_____ _____

EMPLOYER INFORMATION

Name _____ Employer FEIN _____

UI Number _____ Manual Classification Code _____

Industry Code _____

Info/Attn _____

Mailing Address _____

City _____ State _____

Postal Code _____ Country _____

Physical Addr _____

City _____ State _____

Postal Code _____ Country _____

Contact Name _____

Contact Business Phone Number _____

INSURED INFORMATION

Insured Name _____ Insured FEIN _____

Insured Type ☐ Insured ☒ Self-Insured ☐ Uninsured Insured Location ID _____

Policy Number ID n/a _____

Policy Effective Date _____ Policy Expiration Date _____

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

The above information is true to the best of my knowledge and belief.

If prepared by the employer:

Signature of Person Preparing Form _____ Date _____

Print Name _____

Title _____ Phone Number _____