NEW YORK STATE OF OPPORTUNITY.

Office of General Services
Business Services Center

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Accident Reporting Form (BSC-B20)

Instructions: This form is to be completed due to a work injury or work-related illness. This form is used to either apply for Workers' Compensation benefits, or to be filled out and kept on file for record only. Please note that if completing this form to apply for benefits, it must be done within two years of the date of injury/illness.

1. Fill-out this form - type or print clearly.
2. Print out and sign form.
3. Email the completed and signed form by mail, fax or email to the BSC Human Resources Benefits Unit.

WCB Case Number (If you know it)

A. EMPLOYEE INFORMATION

1. First Name MI Last Name	2. Date of Birth: MM/DD/YYYY - -	3. Social Security Number Last 4 Digits XXX - XX -	4. Phone Number ( ) -
5. Mailing Address: Street or PO Box		City	State Zip Code

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 EMPLOYERS

1. Agency When Injured	2. Phone Number ( ) -
3. Your Work Mailing Address: Street or PO Box	City State Zip Code

4. Date You Were Hired: MM/DD/YYYY - -	5. 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 as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB ON THE DATE OF INJURY OR ILLNESS

1. What was your job title?	3. Was Your Job (check one) ☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Volunteer ☐ Other:
2. What types of activities did you normally perform at work?	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/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? *If no, why were you at this location?
☐ Yes ☐ No*

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)

D. YOUR INJURY OR ILLNESS continued

8. Was an object (e.g. forklift, hammer, acid) involved in the injury/illness? *If yes, what?

☐ Yes* ☐ No

9. Was the injury the result of the use of operation of a licensed motor vehicle? ☐ Yes* ☐ No If yes ☐ Your Vehicle ☐ Employer's Vehicle ☐ Other Vehicle License Plate # (if known)

If your vehicle was involved, give the 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 given notice (MM/DD/YYYY) - -

11. Did anyone see your injury happen? *If yes, list names

☐ Yes* ☐ No ☐ Unknown

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 ☐ Partial 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 ☐ Doctor's Office ☐ Hospital stay over 24 hours ☐ Emergency Room ☐ Clinic/Hospital/Urgent Care

4. Are you still being treated for this injury/illness?

☐ Yes, date of treatment → - - ☐ No

Give the name and address of the doctor(s) treating you for this injury/illness

Phone Number

( ) -

Name and address of where you were first treated

Name of Treating Physician

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 BSC-B21 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.**

☐ **I am completing and submitting this form for record purposes only.**

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.

Supervisor (on behalf of the employee) | **Print Name** | **Date**

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**

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ID No., if any | **If Licensed Representative, License No.** | **Expiration Date**