Employee Claim
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.ny.gov.

WCB Case Number (if you know it):

A. YOUR INFORMATION (Employee)
1. Name: ________________________________ 2. Date of Birth: ______/_____/_____
   First  Middle  Last
3. Mailing address: ____________________________
   Number and Street/PO Box  City  State  Zip Code
4. Social Security Number: ___________  5. Phone Number: (_____)________________________
5. Your work address: ____________________________
   Number and Street/PO Box  City  State  Zip Code
6. List names/addresses of any other employer(s) at the time of your injury/illness: ____________________________

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/PO Box  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):
   ________________________________________
YOUR NAME: ____________________________________________ DATE OF INJURY/ILLNESS: ______/______/______

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: ____________________________________________  Date: _____/_____/_____
On behalf of Employee: ____________________________________________  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:  ________________________________  If Licensed Representative, License No.: ________________________________  Expiration Date: _____/_____/_____

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Limited Release of Health Information
(HIPAA)
State of New York - Workers' Compensation Board

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 Advocates 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. www.wcb.ny.gov
Section E - Return to Work (cont):

Item 2: If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)

Item 3: If you have returned to work, indicate who you are working for now.

Item 4: Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

Section F - Medical Treatment for This Injury or Illness:

Item 1: If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.

Item 2: Check if you were first treated on the job for this injury or illness.

Item 3: Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).

Item 4: If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise check No.

Item 5: If you believe you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and complete and file Form C-3.3 together with this form.

Item 6: If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for "Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative must complete and sign the attorney/representative's certification section on the bottom of page 2.

What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the Workers' Compensation Board centralized mailing address. Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, contact the Workers' Compensation Board at 1-877-632-4996.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed, the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, his/her fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

This form should be filed by sending directly to the address listed below:

New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Number: 877-632-4996