For a Leave of absence due to a reported on the job injury

Please provide a memo stating the dates of your leave and the following information:

-Name
-Employee ID number
-Your last day in the office
-Date of Injury and Case Number
-Current home address and phone number or the address and phone number for where you will be staying during the leave
-Work location address and phone number
-Supervisor &/ Manager's name and phone number…

-If you would like your remaining checks mailed to you (when direct deposit ceases) please state so in your memo….

-Please be advised that you must inform your supervisor &/ manager of your leave request.

- The medical documentation must be on letterhead of a licensed practitioner stating you are under the practitioner's care, indicating the diagnosis, prognosis, and the expected return date.

-A completed Workers Compensation package must be submitted

-When all leave balances and/or grants have been exhausted, your leave will be placed in Option 2. Please contact the NYC Law Department, Workers Compensation Division, to request payment.

-Please be advised that the maximum time allowed by this agency to be out on a leave of absence for a work related injury is 1 year consecutively or cumulatively per case.

Send memo and Workers' Compensation packet / or medical documentation to
NYC Administration for Children's Services
ATTN Employee Relations
150 William Street, 16th Floor
New York, New York 10038
212-341-2553
212-341-2574

THE CITY OF NEW YORK

WORKERS' COMPENSATION CLAIM INITIATION

ACCIDENT DESCRIPTION CODES

FISA FORM WCS-108C (5/00)

NATURE OF INJURY

SI SPECIFIC INJURY

- 02 AMPUTATION
- 03 ANGINA PECTORIS (Chest Pains)
- 04 BURN
- 07 CONCUSSION
- 10 CONTUSION
- 13 CRUSHING
- 16 DISLOCATION
- 19 ELECTRIC SHOCK
- 22 ENUCLEATION (To Remove Eye Tumor, Etc)
- 25 FOREIGN BODY
- 28 FRACTURE
- 30 FREEZING
- 31 HEARING LOSS, TRAUMATIC
- 32 HEAT PROSTRATION
- 34 HERNIA
- 36 INFECTION
- 37 INFLAMMATION
- 40 LACERATION (CUT)
- 41 MYOCARDIAL INFARCTION (Heart Attack)
- 43 PUNCTURE
- 46 RUPTURE
- 47 SEVERANCE (CUT OFF)
- 49 SPRAIN
- 52 STRAIN
- 54 ASPHYXIATION
- 55 VASCULAR LOSS
- 58 VISION LOSS
- 59 ALL OTHER

OD Occupation Disease

- 60 DUST DISEASE
- 61 ASBESTOSIS
- 62 BLACK LUNG
- 63 BYSSINOSIS
- 64 SILICOSIS
- 65 RESPIRATORY DISORDERS (Gas, Fumes etc)
- 66 POISONING - CHEMICAL
- 67 POISONING - METAL
- 68 DERMATITIS
- 69 MENTAL DISORDER
- 70 RADIATION
- 71 ALL OTHER OCCUPATIONAL DISEASE
- 72 HEARING LOSS (Non-Traumatic)
- 73 CONTAGIOUS DISEASE
- 74 CANCER
- 75 AIDS
- 76 VDT RELATED DISEASE
- 77 MENTAL STRESS
- 78 CARPAL TUNNEL SYNDROME
- 80 ALL OTHER CUMULATIVE INJURIES

CAUSE OF ACCIDENT

EX EXPOSURE

- 01 ACID OR CHEMICALS
- 02 CONTACT WITH HOT OBJECT
- 03 TEMPERATURE EXTREMES
- 04 FIRE OR FLAME
- 05 STEAM OR HOT FLUID
- 06 DUST/GASSES/FUMES/VAPORS
- 07 WELDING OPERATION
- 08 RADIATION
- 09 MISCELLANEOUS

CB CAUGHT IN OR BETWEEN

- 10 MACHINE OR MACHINERY
- 12 OBJECT HANDLED
- 13 MISCELLANEOUS

CP CUT/PUNCTURE

- 15 BROKEN GLASS
- 16 HAND TOOL/UTENSIL (NONPOWERED)
- 18 POWERED HAND TOOL/APPLIANCE
- 19 MISCELLANEOUS

FS FALL OR SLIP

- 25 FROM DIFFERENT LEVEL
- 26 FROM LADDER OR SCAFFOLD
- 27 ON LIQUID OR GREASE SPILL
- 29 ON SAME LEVEL
- 30 SLIPPED, WITHOUT FALLING
- 31 MISCELLANEOUS

MV MOTOR VEHICLE

- 45 COLLISION WITH OTHER VEHICLE
- 46 COLLISION WITH FIXED OBJECT
- 47 CRASH OF AIRPLANE
- 48 VEHICLE UPSET
- 50 MISCELLANEOUS

SN STRAIN OR INJURY

- 54 JUMPING
- 55 HOLDING OR CARRYING
- 56 LIFTING
- 57 PUSHING OR PULLING
- 58 REACHING
- 59 USING TOOL OR MACHINERY
- 60 MISCELLANEOUS

SA STRIKING AGAINST OR STEPPING ON

- 65 MOVING PART(S) OF MACHINERY
- 66 OBJECT BEING LIFTED/HANDLED
- 67 SAND, SCRAP OR CLEANING OPERATION
- 68 STATIONARY OBJECT
- 69 STEPPING ON SHARP OBJECT
- 70 MISCELLANEOUS

SK STRUCK OR INJURED BY

- 75 FALLING/FLYING OBJECT
- 76 HAND TOOL/MACHINE IN USE
- 77 MOTOR VEHICLE
- 78 MOVING PART(S) OF MACHINE
- 79 OBJECT BEING LIFTED/HANDLED
- 80 OBJECT HANDLED BY OTHERS
- 81 MISCELLANEOUS

MS MISCELLANEOUS CAUSES

- 84 ELECTRIC CURRENT CONTACT
- 85 ANIMAL OR INSECT
- 86 EXPLOSION OR FLARE BACK
- 87 FOREIGN BODY IN EYE
- 89 ROBBERY/CRIMINAL ASSAULT
- 97 REPETITIVE MOTION
- 98 CUMULATIVE (ALL OTHER)
- 99 OTHER

BODY PART(S) AFFECTED

HN HEAD

- 10 MULTIPLE HEAD INJURIES
- 11 SKULL
- 12 BRAIN
- 13 EAR (LEFT, RIGHT OR BOTH)
- 14 EYE (LEFT, RIGHT OR BOTH)
- 15 NOSE
- 16 TEETH
- 17 MOUTH
- 18 OTHER SOFT FACIAL TISSUE
- 19 FACIAL BONES

HN NECK

- 20 MULTIPLE NECK INJURIES
- 21 VERTEBRAE (NECK BONES)
- 22 DISC
- 23 SPINAL CORD
- 24 LARYNX (VOICE BOX)
- 25 SOFT TISSUE
- 26 TRACHEA (WIND PIPE)

UE UPPER EXTREMITIES

- 30 MULTIPLE INJURIES
- 31 UPPER ARM - INCLUDING SHOULDER (LEFT, RIGHT OR BOTH)
- 32 ELBOW (LEFT, RIGHT OR BOTH)
- 33 LOWER ARM (LEFT, RIGHT OR BOTH)
- 34 WRIST (LEFT, RIGHT OR BOTH)
- 35 HAND (LEFT, RIGHT OR BOTH)
- 36 FINGER(S) (LEFT, RIGHT OR BOTH)
- 37 THUMB (LEFT, RIGHT OR BOTH)

TR TRUNK

- 40 MULTIPLE TRUNK
- 41 UPPER BACK AREA
- 42 LOWER BACK AREA
- 43 DISC
- 44 CHEST (RIBS, BREAST BONE, TISSUE)
- 45 SACRUM/COCCYX, BUTTOCKS
- 46 PELVIS
- 47 SPINAL CORD
- 48 INTERNAL ORGAN
- 49 HEART

LE LOWER EXTREMITIES

- 50 MULTI INJURIES (LEFT, RIGHT OR BTH)
- 51 HIP (LEFT, RIGHT OR BOTH)
- 52 THIGH (LEFT, RIGHT OR BOTH)
- 53 KNEE (LEFT, RIGHT OR BOTH)
- 54 LOWER LEG (LEFT, RIGHT OR BOTH)
- 55 ANKLE (LEFT, RIGHT OR BOTH)
- 56 FOOT (LEFT, RIGHT OR BOTH)
- 57 TOE(S) (LEFT, RIGHT OR BOTH)

THE CITY OF NEW YORK
WORKERS' COMPENSATION CLAIM INITIATION
EMPLOYEE STATEMENT

FISA FORM WCS-110 (1/01)

CLAIM NUMBER

INJURED EMPLOYEE NAME

FIRST NAME | M.I. | LAST NAME | EMPLOYEE ID

EMPLOYEE'S ADDRESS

STREET LOCATION | APT #, FL.#, BOX #

BORO, CITY OR TOWN | STATE | ZIP

DATE OF ACCIDENT / INJURY (MM-DD-YYYY)

TIME OF ACCIDENT (HH:MM) AM ☑ PM ☐

WORK TEL # (AREA CD) | EXTENSION

HOME TEL # (AREA CD)

DATE OF STATEMENT (MM-DD-YYYY)

OF WITNESS(ES)

SUPERIOR NOTIFIED

FIRST NAME | M.I. | LAST NAME | DATE FIRST NOTIFIED (MM-DD-YYYY)

TITLE

WORK TEL # (AREA CD) | EXTENSION

DESCRIBE LOCATION WHERE ACCIDENT OCCURRED

☐ CONTINUATION #1 ATTACHED

DESCRIBE FULLY HOW ACCIDENT OCCURRED

☐ CONTINUATION #2 ATTACHED

DESCRIBE OBJECT OR SUBSTANCE THAT CAUSED INJURY

☐ CONTINUATION #3 ATTACHED

DESCRIBE NATURE AND EXTENT OF INJURY (INCLUDING AFFECTED BODY PARTS)

☐ CONTINUATION #4 ATTACHED

NAME (PLEASE PRINT) | TITLE | TEL.#

SIGNATURE | DATE

Reset Form

THE CITY OF NEW YORK
WORKERS' COMPENSATION CLAIM INITIATION
WITNESS STATEMENT

FISA FORM WCS-120 (8/00)

CLAIM NUMBER

INJURED EMPLOYEE NAME

FIRST NAME | M.I. | LAST NAME | EMPLOYEE ID

WITNESS INFORMATION

FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

STREET LOCATION (INCLUDE APT / FL #)

HOME ADDRESS

BORO, CITY OR TOWN | STATE | ZIP | PLUS 4

WORK TEL # (AREA CD)

HOME TEL# (AREA CD)

ARE YOU A CITY EMPLOYEE? ☐ YES ☐ NO

RELATIONSHIP TO INJURED

DATE OF ACCIDENT / INJURY (MONTH / DAY / YEAR)

TIME OF ACCIDENT (HOUR : MINUTE) ☐ AM ☐ PM

LIST OTHER PERSONS WHO ALSO MIGHT HAVE WITNESSED ACCIDENT

ATTACH NAMES OF ADDITIONAL WITNESSES

☐ *CONTINUATION ATTACHED*

FIRST NAME	M.I.	LAST NAME

DESCRIPTION OF ACCIDENT - INCLUDING LOCATION

☐ *CONTINUATION ATTACHED*

NAME (PLEASE PRINT) | TITLE | TEL.#

SIGNATURE | DATE

Exhibit B26-3: **Form DP2002**

THE CITY OF NEW YORK

Election of rate of Charge Against Annual and /or Sick Leave Balances for Absence Due to Injury Sustained in the Performance of Official Duties

(Pursuant to Regulation 7.0 of the Leave regulations for employees who are under the Career and Salary Plan)

INSTRUCTIONS: The injured employee, or an authorized person action in his behalf, should submit this election notice (in duplicate) to the head of his department or agency within the first seven calendar days of absence due to injury sustained in the performance of official duties.

I, _____ employed in _____
(Print name of injured employee) (Print name of City department or agency)

in a position which is subject to the Leave regulations for employees who are under the Career and Salary Plan, or my authorized agent, do hereby elect the option designated below, subject to the conditions attached thereto, as the one to be applied in determining the charge, if any, to be made against my annual and/or sick leave balances for absence due to injury sustained in the performance of my official duties.

(Check one option only)

☑ **OPTION 1:** I elect to receive the difference between the amount of my weekly salary and the compensation rate, subject to the following conditions:

(a) A pro-rated charge shall be made against my sick leave and/or annual leave balances equal to the number of working days of absence less the number of working days represented by the Worker's Compensation payments, and;

(b) My accrued sick leave and/or annual leave balances, or such leave credits advanced to me in accordance with the Career and Salary Plan Leave regulations, are adequate to meet the charges made against them for supplementary pay, and;

(c) The injury sustained by me was not the result of my willful gross disobedience of safety rules or my willful failure to use a safety device, nor was I under the influence of alcohol, or narcotics at the time of injury, nor did I willfully intend to bring about injury or death upon myself or another, and;

(d) Such medical examinations will be undergone by me as requested by the Worker's Compensation Division of the Law Department and my agency, and when found fit for duty by said physicians, I shall return to my employment.

☐ **OPTION 2:** I elect to receive Worker's Compensation benefits in their entirety with no charge against sick and/or annual leave.

Injured employee's signature	◆	Date
This shaded section should be completed only if the injured employee cannot sign and must designate an authorized person to sign in his behalf	Authorized designee's name (Print)	Relationship to employee
	Authorized designee's address	
	Witness' name (Print)	
	Witness' address	
	Witness' signature	Date

ASSIGNMENT

(PURSUANT TO SECTION 7.2 OF THE LEAVE REGULATIONS FOR CAREER & SALARY PLAN EMPLOYEES)

INSTRUCTIONS: EXECUTE IN DUPLICATE AND SUBMIT TO EMPLOYING AGENCY; THE EMPLOYING AGENCY WILL FORWARD THE DUPLICATE COPY OF THE WORKERS' COMPENSATION SECTION OF THE LAW DEPARTMENT.

KNOW ALL MEN BY THESE PRESENTS, THAT I _____

RESIDING AT (FULL ADDRESS) _____

AND EMPLOYED BY THE CITY OF NEW YORK AS _____, ASSIGNED TO THE DEPARTMENT

OF _____, FOR AND IN CONSIDERATION OF BEING GRANTED A LEAVE OF ABSENCE WITH PAY BY THE CITY OF NEW YORK, PURSUANT TO SECTION 7.2 OF THE LEAVE REGULATIONS FOR NEW YORK CITY EMPLOYEES WHO ARE UNDER THE CAREER AND SALARY PLAN, DO HEREBY ASSIGN, TRANSFER, AND SET OVER UNTO THE CITY OF NEW YORK SUCH PART OR CLAIM I MAY HAVE OF WHICH MIGHT BE BROUGHT ON MY BEHALF AGAINST SUCH PERSON OR PERSONS, PARTY OR PARTIES, ASSOCIATIONS OR CORPORATIONS AS MAY BE LIABLE TO ME OR TO MY REPRESENTATIVE FOR THE INJURY SUSTAINED BY ME AND FOR WHICH I HAVE RECEIVED A LEAVE OF ABSENCE WITH PAY FROM THE CITY OF NEW YORK, AS SHALL BE EQUAL TO THE PAY THAT I RECEIVE FROM THE CITY OF NEW YORK DURING MY LEAVE OF ABSENCE AND TO ANY MEDICAL DISBURSMENTS MADE BY THE CITY OF NEW YORK IN MY BEHALF.

I HEREBY AUTHORIZE THE CITY OF NEW YORK TO COLLECT THE AMOUNT PAID ME BY THE CITY OF NEW YORK DURING MY LEAVE OF ABSENCE AND THE AMOUNT OF ANY MEDICAL DISBURSEMENTS PAID BY THE CITY OF NEW YORK IN MY BEHALF FROM THE PARTY OR PARTIES WHO SHALL BE OR BECOME INDEBTED TO ME AS THE RESULT OF ANY JUDGEMENT OR SETTLEMENT OF ANY ACTION OR CLAIM ARISING FROM THE INJURY SUSTAINED BY ME FOR WHICH I RECEIVED A LEAVE OF ABSENCE WITH PAY FROM THE CITY OF NEW YORK, AND I FURTHER STIPULATE AND CONSENT THAT THE SUMS PAID TO ME BY THE CITY OF NEW YORK DURING MY LEAVE OF ABSENCE AND ANY MEDICAL DISBURSEMENTS PAID BY THE CITY OF NEW YORK IN MY BEHALF SHALL CONSTITUTE A PRIMARY LIEN WHICH MAY BE PLACED OR CHARGED AGAINST SUCH ACTION, CLAIM AND/OR FUNDS SECURED AS A RESULT OF SUCH ACTION OR CLAIMS AS I MAY HAVE, REGARDLESS OF WHO MAY BE IN POSSESSION OF SUCH FUNDS.

I HEREBY AUTHORIZE AND DIRECT SUCH PERSON OR PERSONS, PARTY OR PARTIES, FIRM OR FIRMS, CORPORATION OR CORPORATIONS WHO WILL OR MAY BECOME INDEBTED TO ME BY REASON OF THE AFORESAID INJURY SUSTAINED BY ME, TO PAY TO THE CITY OF NEW YORK, AS SUCH ASSIGNEE, OUT OF THE AMOUNT DUE OR WHICH MAY BECOME DUE TO ME. SUCH SUMS AS ARE CLAIMED BY THE SAID CITY FOR THE AMOUNT OF MONEY GIVEN TO ME BY THE CITY DURING MY LEAVE OF ABSENCE, AND FOR ANY MEDICAL DISBURSEMENTS PAID BY THE CITY IN MY BEHALF, WITHOUTH FURTHER NOTICE TO SUCH PARTIES FROM ME, AND I HEREBY AGREE TO HOLD SUCH PARTIES HARMLESS ON ACCOUNT OF SUCH PAYMENTS.

I HEREBY AUTHORIZE AND DIRECT MY ATTORNEY OR ATTORNEYS, OR OTHER PERSON OR PERSONS, INTO WHOSE HANDS OR POSSESSION ANY OF THE PROCEEDS SHALL COME, TO HOLD IN TRUST FOR AND TO PAY OVER TO THE CITY OF NEW YORK, SUCH SUMS AS ARE CLAIMED BY SAID CITY TO HAVE BEEN PAID TO ME BY THE CITY DURING MY LEAVE OF ABSENCE AND SUCH SUMS, IF ANY, WHICH HAVE BEEN PAID BY THE CITY FOR MEDICAL DISBURSEMENTS IN MY BEHALF.

IN WITNESS WHEREOF, I HAVE HEREUNTO SET MY HANDS THIS _____ DAY OF _____, 20_____.

STATE OF NEW YORK) SS.:
COUNTY OF NEW YORK)

ON THIS _____ DAY OF _____, 20_____, BEFORE ME PERSONALLY APPEARED

_____, TO ME KNOWN AND KNOWN TO ME TO BE THE INDIVIDUAL DESCRIBED IN AND WHO EXECUTED THE FOREGOING INSTRUMENT AND DULY ACKNOWLEDGED TO ME THAT HE EXECUTED THE SAME.

_____

I HAVE FULL KNOWLEDGE OF ASSIGNMENT ABOVE.
ATTORNEY'S SIGNATURE _____

NAME AND ADDRESS _____
OF THE DEFENDANT _____

NAME AND ADDRESS _____
OF THE LIABILIBY INSURANCE CARRIER _____

THE CITY OF NEW YORK - WORKERS' COMPENSATION CLAIM INITIATION

Supervisor's/Agency - "REPORT OF INJURY"

Reset Form | Validate Form

FISA FORM WCS-100 (4/09) (CONTINUED ON REVERSE SIDE)

CLAIM NUMBER

INJURED EMPLOYEE NAME

FIRST NAME | M.I. | LAST NAME | EMPLOYEE ID

EMPLOYEE'S ADDRESS

STREET LOCATION | APT #, FL.#, BOX #

BORO, CITY OR TOWN | STATE | ZIP

DATE OF ACCIDENT / INJURY (MONTH DAY YEAR) | TIME OF ACCIDENT (HOUR MINUTE AM PM) | WAS EMPLOYEE ABSENT DUE TO INJURY? YES NO | INITIAL ABSENCE DATE (MONTH DAY YEAR) | INITIAL ABSENCE TIME (HOUR MINUTE AM PM)

TIME EMPLOYEE BEGAN WORK (HOUR MINUTE AM PM) | IS EMPLOYEE EXPECTED TO RETURN TO WORK? YES NO | INJURED WORKER'S WORK WEEK (SUN MON TUE WED THU FRI SAT) *(ENTER AN "X" FOR DAYS USUALLY WORKED)* | HAS EMPLOYEE RETURNED TO WORK? YES NO | RETURN TO WORK DATE (MONTH DAY YEAR)

WAS EMPLOYEE PAID FOR A FULL DAY ON THE DAY OF THE INJURY/ILLNESS? YES NO

HAS THE EMPLOYEE GIVEN YOU NOTICE OF INJURY/ILLNESS? YES NO

IF YES, NOTICE WAS GIVEN TO: ORALLY IN WRITING | DATE NOTICE PROVIDED (MONTH DAY YEAR)

SUPERVISOR'S

FIRST NAME | M.I. | LAST NAME

TITLE | (AREA CD) | WORK TELEPHONE # | EXTENSION

WAS ACCIDENT ON EMPLOYER'S PREMISES? YES NO

DID ACCIDENT OCCUR DURING WORK HOURS? YES NO

DID ACCIDENT OCCUR DURING LUNCH BREAK? YES NO

WAS EMPLOYEE TRAVELING TO/FROM WORK? YES NO

WAS EMPLOYEE TRAVELING BETWEEN WORK SITES? YES NO

DID ACCIDENT OCCUR AT NORMAL WORK SITE LOCATION? YES NO

IF NO, EXACT LOCATION AND COUNTY OF ACCIDENT REQUIRED

IF ACCIDENT DID NOT OCCUR AT NORMAL WORK SITE, AN EXPLANATION OF WHY EMPLOYEE WAS AT ACCIDENT SITE IS REQUIRED

WAS EMPLOYEE ON SPECIAL OR WORK RELATED FIELD ASSIGNMENT? YES NO

IF YES, DESCRIBE FIELD ASSIGNMENT

CONTINUATION #1 ATTACHED

WAS INJURY WITNESSED BY SUPERVISOR? YES NO *INJURY DESCRIPTION AS WITNESSED BY SUPERVISOR OR AS REPORTED MUST BE PROVIDED BELOW*

CONTINUATION #2 ATTACHED

DID EMPLOYEE FOLLOW STANDARD PROCEDURES AT TIME OF ACCIDENT? YES NO

IF NO, DETAILS REQUIRED

CONTINUATION #3 ATTACHED

DID EMPLOYEE'S ACTION OR BEHAVIOR CONTRIBUTE TO THE ACCIDENT? YES NO

IF YES, DETAILS REQUIRED

CONTINUATION #4 ATTACHED

ARE DISCIPLINARY ACTIONS PENDING OR CONSIDERED AGAINST EMPLOYEE? YES NO

IF YES, DETAILS REQUIRED

CONTINUATION #5 ATTACHED

DOES THE AGENCY RECOMMEND TO CONTROVERT? YES NO

IF YES, DETAILS REQUIRED

CONTINUATION #6 ATTACHED

WHAT WAS THE DATE OF EMPLOYEE'S FIRST TREATMENT? (MONTH DAY YEAR) NONE RECEIVED UNKNOWN

WHERE DID THE EMPLOYEE RECEIVE FIRST MEDICAL TREATMENT FOR THIS INJURY/ILLNESS? ON SITE | DOCTOR'S OFFICE | EMERGENCY ROOM | CLINIC/ HOSPITAL/ URGENT CARE | HOSPITAL STAY OVER 24 HOURS | UNKNOWN

WHO TREATED THE EMPLOYEE AND WHERE?

IS THE EMPLOYEE STILL BEING TREATED FOR THIS INJURY/ILLNESS? YES NO UNKNOWN

IF YES, PLEASE ENTER THE NAME AND ADDRESS OF TREATING DOCTOR(S) IN THE DOCTOR SECTION BELOW.

TO YOUR KNOWLEDGE, DID THE EMPLOYEE HAVE ANOTHER WORK-RELATED INJURY TO THE SAME BODY PART OR A SIMILAR ILLNESS WHILE WORKING FOR YOU? YES NO

IF YES, NAME THE DOCTOR(S) WHO TREATED THE PREVIOUS INJURIES/ILLNESSES (IF KNOWN):

DOCTOR

NAME: FIRST | M.I. | LAST

ADDRESS: STREET LOCATION

BORO, CITY OR TOWN | STATE | ZIP | PLUS 4

DOCTOR

NAME: FIRST | M.I. | LAST

ADDRESS: STREET LOCATION

BORO, CITY OR TOWN | STATE | ZIP | PLUS 4

ADDITIONAL INFORMATION: _____

WAS AN OBJECT (E.G HAMMER, ACID) INVOLVED IN THE INJURY/ILLNESS? ☐ YES ☐ NO

IF YES, WHAT WAS IT? _____

INJURY DESCRIPTION *(SEE CODE TABLE FOR DETAILED INJURY, CAUSE & BODY PART DESCRIPTION CODE BREAKDOWN*

NATURE OF INJURY	INJURY TYPE	INJURY CODE	DESCRIPTION
	SI ☐ SPECIFIC INJURY ☐ OD OCCUPATIONAL DISEASE	☐☐	

☐ *CONTINUATION #8 ATTACHED*

CAUSE OF ACCIDENT — CAUSE CODE ☐☐

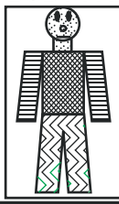
CAUSE TYPE (CHECK ONE): ☐ EXPOSURE(EX) ☐ FALL/SLIP(FS) ☐ STRIKING AGAINST/STEP ON(SA) ☐ CAUGHT BETWEEN(CB) ☐ MOTOR VEHICLE(MV) ☐ STRUCK/INJURED(SK) ☐ CUT/PUNCTURE(CP) ☐ STRAIN/INJURED (SN) ☐ MISCELLANEOUS CAUSE(MS)

DESCRIPTION

☐ *CONTINUATION #9 ATTACHED*

BODY PART(S) AFFECTED

(INDICATE INJURED BODY PART CODE, DESCRIPTION AND SIDE(S) AFFECTED, IF APPLICABLE)



BODY SECTION CODES: HN (HEAD/NECK), UE (UPPER), TR (TRUNK), LE (LOWER)

BODY SECTION ☐☐ / PART CODE ☐☐	DESCRIPTION: ☐ LEFT ☐ RIGHT ☐ BOTH	BODY SECTION ☐☐ / PART CODE ☐☐	DESCRIPTION: ☐ LEFT ☐ RIGHT ☐ BOTH	BODY SECTION ☐☐ / PART CODE ☐☐	DESCRIPTION: ☐ LEFT ☐ RIGHT ☐ BOTH
BODY SECTION ☐☐ / PART CODE ☐☐	DESCRIPTION: ☐ LEFT ☐ RIGHT ☐ BOTH	BODY SECTION ☐☐ / PART CODE ☐☐	DESCRIPTION: ☐ LEFT ☐ RIGHT ☐ BOTH	BODY SECTION ☐☐ / PART CODE ☐☐	DESCRIPTION: ☐ LEFT ☐ RIGHT ☐ BOTH

EMPLOYEE'S JOB DESCRIPTION

JOB TASK AT TIME OF INJURY — FUNCTIONAL TITLE & DESCRIPTION (ATTACH JOB DESCRIPTION IF AVAILABLE)

EMPLOYEE'S JOB WAS (CHECK ONE): ☐ FULL TIME ☐ PART TIME

TYPICAL WORKDAY (8 HR. MAX.)

SITTING		STANDING		WALKING	
HOUR	MINUTE	HOUR	MINUTE	HOUR	MINUTE
☐☐ :	☐☐	☐☐ :	☐☐	☐☐ :	☐☐

TYPICAL WORKDAY TASKS / INDICATE WORKDAY ACTIVITY %

ACTIVITY	0 % (N / A)	10 % (MINIMAL)	20 % (OCCASIONAL)	35 % (MODERATE)	50 % (FREQUENT)	70 - 100 % (CONTINUOUS)
BENDING / SQUATTING	A	B	C	D	E	F
CLIMBING	A	B	C	D	E	F
KNEELING	A	B	C	D	E	F
LIFTING * *Complete Lifting Detail Section*	A	B	C	D	E	F
REACHING ABOVE SHOULDER	A	B	C	D	E	F
PUSH / PULL	A	B	C	D	E	F

LIFTING DETAILS

*LIFTING	0 % (N / A)	10 % (MINIMAL)	20 % (OCCASIONAL)	35 % (MODERATE)	50 % (FREQUENT)	70 - 100 % (CONTINUOUS)
UP TO 10 POUNDS	A	B	C	D	E	F
11 TO 20 POUNDS	A	B	C	D	E	F
21 TO 30 POUNDS	A	B	C	D	E	F
31 TO 50 POUNDS	A	B	C	D	E	F
OVER 50 POUNDS	A	B	C	D	E	F

INDICATE THE PERCENTAGE OF WEIGHT LIFTED PER CATEGORY DURING A TYPICAL WORKDAY

IS KEYBOARD USED? YES ☐ NO ☐ IF YES, HOW MANY HRS PER WEEK? ☐☐

ARE HANDS USED FOR NON KEYBOARD REPETITIVE MOTION? YES ☐ NO ☐ IF YES, EXPLAIN WHAT OTHER REPETITIVE MOTIONS ARE PERFORMED? _____

IS CLAIMANT A SEASONAL EMPLOYEE? ☐ YES ☐ NO

DID ACCIDENT INVOLVE A MOTOR VEHICLE? ☐ YES ☐ NO IF YES, WAS VEHICLE REGISTERED TO THE CITY OF NEW YORK? YES ☐ NO ☐ USE OF CITY VEHICLE AUTHORIZED? YES ☐ NO ☐ EMPLOYEE STRUCK BY CITY VEHICLE? YES ☐ NO ☐ EMPLOYEE DRIVING A CITY VEHICLE? YES ☐ NO ☐

WAS INJURED ON PUBLIC TRANSPORTATION? YES ☐ NO ☐ IF YES, EXPLAIN DOES EMPLOYEE OWN THE VEHICLE? YES ☐ NO ☐

☐ *CONTINUATION #12 ATTACHED*

WAS EMPLOYEE A VEHICLE PASSENGER? YES ☐ NO ☐

DID EMPLOYEE DIE FROM INJURY? YES ☐ NO ☐ *IF YES, ANSWER THE FOLLOWING QUESTIONS*

DATE EMPLOYEE DIED: MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐☐☐ TIME EMPLOYEE DIED: HOUR ☐☐ : MINUTE ☐☐ AM ☐ PM ☐

NAME OF NEAREST RELATIVE — FIRST _____ M.I. ☐ LAST NAME _____

RELATIONSHIP _____ HOME TELEPHONE # ☐☐☐ ☐☐☐-☐☐☐☐

ADDRESS — STREET LOCATION (INCLUDE APT/FL#) _____

BORO, CITY OR TOWN _____ STATE ☐☐ ZIP ☐☐☐☐☐ PLUS 4 ☐☐☐☐

IDENTIFY PERTINENT DOCUMENTATION (e.g. Police Report, Safety Reports, etc.) _____

☐ *CONTINUATION #10 ATTACHED*

WAS INJURY CAUSED BY ASSAULT ON THE JOB? ☐ YES ☐ NO *IF YES, PROVIDE INFORMATION BELOW*

ASSAILANT WAS: ☐ CO - WORKER ☐ FRIEND, FAMILY OR ACQUAINTANCE ☐ CLIENT ☐ OTHER _____ ☐ OFFENDER ☐ OWNER / OPERATOR ☐ OUTSIDE CONTRACTOR

ASSAULTED BY

NAME OF ASSAILANT — FIRST _____ M.I. ☐ LAST NAME _____

ADDRESS — STREET LOCATION (INCLUDE APT/FL#) _____

BORO, CITY OR TOWN _____ STATE ☐☐ ZIP ☐☐☐☐☐ PLUS 4 ☐☐☐☐

HOME TELEPHONE # ☐☐☐ ☐☐☐-☐☐☐☐ WORK TELEPHONE # ☐☐☐ ☐☐☐-☐☐☐☐ EXTENSION ☐☐☐☐

CAN YOU PROVIDE DETAILED EVENTS PRECEDING ASSAULT? ☐ YES ☐ NO IF YES, EXPLAIN _____

☐ *CONTINUATION #11 ATTACHED*

DID ASSAULT INVOLVE A PERSONAL MATTER? ☐ YES ☐ NO IF YES, EXPLAIN _____

☐ *CONTINUATION #12 ATTACHED*

DID ASSAULT INVOLVE WORK RELATED MATTER? ☐ YES ☐ NO IF YES, EXPLAIN _____

☐ *CONTINUATION #13 ATTACHED*

DID THE EMPLOYEE START, PROVOKE OR PROLONG THE ASSAULT IN ANY WAY? ☐ YES ☐ NO IF YES, EXPLAIN _____

☐ *CONTINUATION #14 ATTACHED*

PREPARED BY (Please Print)	TITLE
SIGNATURE	TEL # / DATE