WORKERS' COMPENSATION BOARD
New York State

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 Perma c/o NEAMI **Insurer ID** W861223

Name Northeast Association Management, Inc.

Info/Attn ______________________

Address 9 Cornell Road

City Latham **State** NY

Postal Code 12110-6407 **Country** ______________

Claim Admin ID T900004

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** ______________ (Last 4 Only)

• **Occupation Description** ______________________

CLAIM INFORMATION

- **Time of Injury** ______
- **Date Employer Had Knowledge of the Injury** ______

Employment Status Active

- **Date Employer Had Knowledge of Date of Disability** ______

Estimated Weekly Wage ______

Number of Days Worked Per Week ______

Work Week Type ☐ Standard Work Week ☐ Fixed Work Week ☐ Varied Work Week

Work Days Scheduled ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

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 ______

Initial Date Disability Began ______

Initial Return to Work Date ______

Return To Work Type ☐ Actual ☐ Released

Physical Restrictions ☐ Yes ☐ No

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** (Please be Specific) ______
- **Witnesses** ______
- **Business Phone Number** ______

EMPLOYER INFORMATION

Name Cayuga-Onondaga BOCES

Employer FEIN 15-600-8079

UI Number ______

Manual Classification Code 8868

Industry Code ______

Info/Attn ______

Mailing Address 1879 West Genesee Street Road

City Auburn

State NY

Postal Code 13021

Country ______

Physical Addr ______

City ______

State ______

Postal Code ______

Country ______

Contact Name ______

Contact Business Phone Number 315-253-0361

INSURED INFORMATION

Insured Name Cayuga-Onondaga BOCES

Insured FEIN 15-600-8079

Insured Type ☒ Insured ☐ Self-Insured ☐ Uninsured

Insured Location ID ______

Policy Number ID WC 0001447-00

Policy Effective Date 07/01/2018

Policy Expiration Date 07/01/2019

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** ______