SUNY MORRISVILLE

EMPLOYEE REPORT OF WORK-RELATED INJURY/ILLNESS

INSTRUCTIONS

EMPLOYEE:

1. WITHIN 24 HOURS OF INCIDENT, OR AS SOON AS POSSIBLE THEREAFTER, CALL THE NYS ACCIDENT REPORTING SYSTEM (ARS) AT 1-888-800-0029.
2. COMPLETE BOTH SIDES OF THIS PAGE, PROVIDING AS MUCH DETAIL AS POSSIBLE. BE SPECIFIC. FOR ALL TIMES, INCLUDE IF AM OR PM. DETACH THIS PAGE AND SUBMIT IT TO YOUR SUPERVISOR.
3. RETAIN AND REVIEW ATTACHED PACKET. SUBMIT THE FORM C-3 TO THE WORKERS COMPENSATION BOARD AS SOON AS POSSIBLE TO ESTABLISH YOUR CASE AND AVOID POTENTIAL LOSS OF BENEFITS. FAX IT TO 877-533-0337.

SUPERVISOR:

1. UPON RECEIPT, OR AS SOON AS POSSIBLE THEREAFTER, COMPLETE YOUR SECTION OF THIS FORM AND SUBMIT IT TO HUMAN RESOURCES,
2. IF EMPLOYEE IS UNABLE TO COMPLETE THIS FORM, COMPLETE AS MUCH AS POSSIBLE OF THE EMPLOYEE SECTION, COMPLETE YOUR SECTION, AND SUBMIT FORM TO HUMAN RESOURCES.

****

Employee information

Name: _____ Dept regularly assigned: _____

Personal daytime phone: _____

Campus phone: _____ Dept assigned at time of incident: _____

Incident date/time

Time began work on day of incident: _____

Date of incident: _____ Time of incident: _____

Date this form/packet received: _____ Time this form/packet received: _____

Date ARS called: _____ Time ARS called: _____

Incident number assigned: _____ Working overtime? YES ◯ NO ◯

Detail of incident – BE VERY SPECIFIC

Location *(building, floor, room, field, walkway, etc.)*: _____

_____

What were you doing immediately prior to incident? *(moving furniture/equipment, climbing ladder, carrying books, walking, etc.)*: _____

_____

What happened? *(slipped on ice, lost my grip, felt a twinge, etc.)*: _____

_____

Describe injury/illness – include body part and left, right, upper, middle, lower *(strained lower back, twisted left ankle, developed skin rash)*: _____

_____

What object was directly involved *(ladder, glass door, spilled chemical)*: _____

_____

(continue on next page)

Notification/Witness

Name(s) of person(s) you notified: _____

Date of notice: _____ Time of notice: _____

Notice provided: VERBALLY ◯ IN WRITING ◯ BOTH ◯

Were there any witnesses? YES ◯ NO ◯

Name of witness(es): _____

Supervisor's name: _____ Did supervisor witness incident? YES ◯ NO ◯

Date supervisor notified: _____ Time supervisor notified: _____

Medical information

Did you receive medical attention? YES ◯ NO ◯

Date of first treatment: _____ Time of first treatment: _____

Type of treatment: ER ◯ Urgent care ◯ Physician's office ◯

Name of facility: _____ Provider's name: _____

Address of facility: _____

Admitted into hospital: YES ◯ NO ◯ Date admitted: _____

Name/address of hospital: _____

Lost time

Did you stop working? YES ◯ NO ◯

Date stopped: _____ Time stopped: _____

Date returned: _____ Time returned: _____

Confirmation

_____ _____

Employee's signature Date

Supervisor's statement

Date notified of incident: _____ Time notified: _____

Did you witness incident? YES ◯ NO ◯

Comments, if any: _____

_____

_____ _____

Supervisor's signature Date

Rev. 03/2015

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
100 BROADWAY-MENANDS
ALBANY, NY 12241
(877) 632-4996

WORKERS' COMPENSATION BOARD

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 medical care as soon as possible.

A Worker's Responsibilities

- You must tell your employer, in writing, when, where and how you were injured. Do this within 30 days of 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 Board and with your employer or its insurance carrier. If your case is disputed, the Board needs a medical report on your injury to begin resolving your claim.

Starting a Case

Once your employer knows of your injury, it must notify this Board. *You should file an employee claim (C-3 form) reporting your injury as soon as possible.* (You **must** notify the Board of your injury or illness within two years.) If you injured the same body part before, or had a similar illness, you must also file a Form C-3.3.

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

- Visit *www.wcb.ny.gov/content/main/onthejob/howto.jsp* to complete the form.
- Complete the enclosed paper forms, and mail them to the Board.
- Call 1-866-396-8314. A Board employee will complete the form with you.

Health Care Bills

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

Your employer's insurance covers medically necessary drugs and equipment 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 Board. You can also use occupational health clinics. However, if your employer's insurer has a preferred provider organization to provide care for workers' compensation injuries, you must get your initial treatment from those providers. If that insurer also has a pharmacy or diagnostic network, you must get service within these networks. If the carrier uses these networks, it must also tell you its service providers and how to use them.

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 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 Board sets their fees and they will be deducted from your lost wages award. You or your family should not pay anything directly to your attorney or licensed representative.

If your case is disputed, you may receive disability benefits while the case is heard. You'd pay them back out of your lost wages award. To get a DB-450 form, visit *www.wcb.ny.gov/content/main/forms/db450.pdf* or a Board office, or call (800) 353-3092.

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 more assistance.

What's Next?

Your employer or its insurance carrier will contact you if your claim is accepted. Your employer may have a *return to work* program that can get you back to work in light duty or an alternative position while you heal. When that happens, your treatment will be paid and lost wage benefits begin. If your case is challenged, the Board will notify you about resolving the case. If more information is necessary, the Board will contact you and tell you how to file it.

Important Contact Information

Workers' Compensation Board	(877)632-4996	General_Information@WCB.NY.Gov
Disability Benefits	(800)353-3092	www.WCB.NY.Gov
NYS Bar Association Lawyer Referral and Information Service	(800)342-3661	lr@nysba.org.

WORKERS' COMPENSATION BOARD

Employee Claim

State of New York - Workers' Compensation Board

C-3

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: _____ (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): _____

_____

_____

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: _____/_____/_____

WORKERS' COMPENSATION BOARD

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 similare 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.

Instructions for Completing Form C-3, "Employee Claim"

Please complete this form and send it to the Workers' Compensation Board centralized mailing address listed at the bottom of these instructions. If you need additional help in completing this form, contact the Workers' Compensation Board at **1-877-632-4996. You may also fill this form out online at: http://www.wcb.ny.gov/**

If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/illness on the top of page two.

Section A - Your Information (Employee):

Item 1: Enter your full name, including first name, middle initial, and last name.
Item 2: Enter your date of birth in month/day/year format. Include the four digit year.
Item 3: Enter your mailing address, including P.O. Box, if applicable, city or town, state, and Zip code.
Item 4: Enter your Social Security Number. This is very important to help service your claim faster.
Item 5: Indicate the primary contact phone number, including area code. This may include a cell phone number.
Item 6: Indicate your gender (Male or Female).
Item 7: Board hearings are conducted in English. If you will need a translator to understand the proceeding, the Board will provide one. Check Yes and indicate the language needed.

Section B - Your Employer(s):

Item 1: Indicate the employer you were working for at the time you were injured or became ill.
Item 2: Enter the phone number for this employer, either a primary contact number or the number for your supervisor.
Item 3: Enter the employer's address, including P.O. Box, if applicable, city or town, state, and Zip code.
Item 4: Indicate the date you were hired by this employer.
Item 5: Enter your direct supervisor's name, whom you report to on a regular basis.
Item 6: If you have more than one job, please indicate the names and addresses of all other employers you work for besides the one you were injured at. Please attach a separate sheet if you need more room.
Item 7: Check Yes if you lost time from any of your other jobs as a result of your injury or illness; otherwise, check No.

Section C - Your Job on the Date of the Injury or Illness:

Item 1: Indicate your current job title or job description (e.g., warehouse worker).
Item 2: Indicate your typical work activities for this job (e.g., keeping inventory, unloading trucks, etc.).
Item 3: Check the type of job you had.
Item 4: Enter your gross pay (before taxes) per pay period.
Item 5: Indicate how often you received a paycheck (weekly, bi-weekly, etc.).
Item 6: Indicate if you received any tips or lodging in addition to your regular pay. If you did, describe them.

Section D - Your Injury or Illness:

Item 1: Enter the date when you were injured or the first date you noticed you became ill. Enter the date in month/day/year format. Include the four digit year. If this is an illness or occupational disease, then skip item 2.
Item 2: Enter the time when the injury occurred. Check whether it was AM or PM.
Item 3: Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
Item 4: Check whether this was your normal work location. If it was not, explain why you were at this location.
Item 5: Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.
Item 6: Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
Item 7: Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible. (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now.)
Item 8: Indicate if some object was involved in the accident OTHER THAN a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
Item 9: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.
Item 10: Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.
Item 11: Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

Section E - Return to Work:

Item 1: If you stopped working as a result of your work-related injury/illness, check Yes and indicate on what date you stopped working. If you have not stopped working, check No and skip to the next section.

NYSIF New York State Insurance Fund

CVS CAREMARK

Workers' Compensation Temporary Prescription Services ID
Important Information

ATTENTION **INJURED WORKER**

This Workers' Compensation Temporary Prescription Services ID form MUST BE PRESENTED to your pharmacist when you fill your initial prescription(s). If you have questions or need to locate a participating pharmacy, please contact CVS Caremark Customer Service at 1-866-493-1640.

ATENCIÓN: TRABAJADOR LESIONADO

Este formulario de Identificación para Servicios Temporales de Prescripción de Recetas por Compensación del Trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es). Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de CVS Caremark, en el teléfono 1.866.493.1640.

Pharmacist/Employer – When form is completed, fax to CVS Caremark: **1-866-493-1644**

Claimant information will be added by CVS Caremark to allow medications to process. This information can also be phoned in at 1-866-493-1640

New York State Insurance Fund	**Group#: NYSIF**
Attention: All items below must be completed.	
AGENCY'S NAME:	INJURED WORKER'S NAME:
	FIRST MI LAST:
AGENCY'S WORKERS' COMPENSATION POLICY NUMBER: 240960	INJURED WORKER'S MAILING ADDRESS:
DATE OF INJURY: __ __ / __ __ / __ __ __ __ MM / DD / CCYY	STREET:
INJURED WORKER'S DATE OF BIRTH: __ __ / __ __ / __ __ __ __	CITY, STATE ZIP
ID#: Injured Worker's Social Security Number	*Help Desk: This is a POS Program through CVS Caremark only. For Assistance call the CVS Caremark Help Desk at: 866.493.1640*

Attention Pharmacist:

New York State Insurance Fund's prescription program is administered by CVS Caremark. The following are the steps necessary to submit a prescription for New York State Insurance Fund claimants.

Please follow the action steps listed below to enter the claim.

Step 1	Enter Bin Number 610235
Step 2	Enter PCN: WRK
Step 3	ID: Injured Worker' Social Security Number

NEED ASSISTANCE? **Pharmacist**, if you have any questions while processing the claim, please call the CVS Caremark Help Desk at **1-866-493-1640.**

NYSIF New York State Insurance Fund

The workers' compensation insurance carrier for employees of New York State is The New York State Insurance Fund (NYSIF) which has a contract with CVS Caremark, a pharmacy benefits manager (PBM) that offers convenient prescription filling services.

NYSIF has implemented an instant enrollment or "short-fill" service with CVS Caremark. The new service allows injured workers immediate acceptance by any pharmacy in the CareComp pharmacy network administered by CVS Caremark. Although New York law does not require us to provide this benefit, we have elected to provide a limited number of cost-effective medication benefits for new claims filed for **work-related injuries or illnesses** in order to help injured workers get through the first, difficult days after an injury and before the claim is accepted.

An employee injured at work should report the injury to the Accident Reporting System (ARS). At this time the employee will be given an ARS incident number.

When submitting a prescription, the injured worker should give the pharmacy the following information:

- The ARS incident number
- GROUP is: NYSIF

The pharmacy should then contact CVS Caremark at 1-866-493-1640.

For instances where an ARS incident number is not able to be obtained right away, the employee should bring the completed "Workers' Compensation Prescription Services ID" form to any pharmacy participating in the CareComp pharmacy network administered by CVS Caremark.

The temporary ID form is completed by the state agency first, then the injured worker.

- Agency fills in:
  - Agency's Name
  - Policy Number (240960)
- Injured worker fills in:
  - First and Last Name
  - Mailing Address
  - Date of Injury
  - Date of Birth
  - Social Security Number

Injured workers can quickly find local participating pharmacies by visiting: www.wcrxpharmacylocator.com or by calling the CVS Caremark 24-hour patient care hotline at 1-866-493-1640.

The injured employee will receive a permanent ID card and packet from CVS Caremark within 10 days of NYSIF's confirmation of the accident. If you have any questions, please contact NYSIF, your workers' compensation carrier, at 1-888-875-5790.

State of New York
WORKERS' COMPENSATION BOARD

Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider

Injured Employee's Name	Injured Employee's Social Security No.	Date of Accident
Employer's Name and Address		

To the Injured Employee:
For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Workers' Compensation Board authorized and who is accepting workers' compensation patients.

While you may choose to utilize a network or provider which is recommended by your employer or its workers' compensation insurance carrier or to permit your employer to select a provider on your behalf, you may, at any time, change your health care provider without jeopardizing your workers' compensation claim for benefits.

Signature of Injured Employee _____ Date _____ Signature of Witness _____ Date _____

Please note: It is not necessary for you to sign this consent form if your employer is (i) participating in a certified preferred provider organization (PPO) under Article 10-A of the Workers' Compensation Law, or (ii) participating in the alternative dispute resolution (ADR) pilot program under section 25(2-c) of the Workers' Compensation Law. In accordance with these statutory programs, except in emergency situations, you must obtain at least initial treatment for any workers' compensation injury or illness from the certified network(s) or providers designated by your employer.

To the Employer:
The employer shall provide the above-named injured employee with a copy of this signed form and shall maintain the original form in the employer's records where it may be inspected by the Workers' Compensation Board at any time. This form shall not be submitted to the Workers' Compensation Board nor shall it be executed prior to the occurrence of this employee's work-related injury or illness.

The Workers' Compensation Board employs and serves people with disabilities without discrimination.