THE CITY OF NEW YORK - WORKERS' COMPENSATION CLAIM INITIATION

Supervisor's/Agency - "REPORT OF INJURY"

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

ARE YOU AWARE OF PRE-EXISTING CONDITIONS? YES NO

IF YES, EXPLAIN CONDITION(S)

CONTINUATION #7 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 — CHILD/ 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

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

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 HOUR : MINUTE	STANDING HOUR : MINUTE	WALKING 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*

ASSAULTANT 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