

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

FISA FORM WCS-110 (1/01)

CLAIM NUMBER

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INJURED EMPLOYEE NAME		EMPLOYEE ID
FIRST NAME	M.I.	LAST NAME
<input type="text"/>	<input type="text"/>	<input type="text"/>
		<input type="text"/>

EMPLOYEE'S ADDRESS	STREET LOCATION	APT #, FL.#, BOX #
	BORO, CITY OR TOWN	STATE ZIP

DATE OF ACCIDENT / INJURY	TIME OF ACCIDENT	WORK TEL #	(AREA CD)	EXTENSION
MM-DD-YYYY	HH-MM AM PM	<input type="text"/>	<input type="text"/>	<input type="text"/>
HOME TEL #	(AREA CD)	DATE OF STATEMENT	# OF WITNESS(ES)	
<input type="text"/>	<input type="text"/>	MM-DD-YYYY	<input type="text"/>	<input type="text"/>

SUPERIOR NOTIFIED			
FIRST NAME	M.I.	LAST NAME	DATE FIRST NOTIFIED
<input type="text"/>	<input type="text"/>	<input type="text"/>	MM-DD-YYYY
TITLE	WORK TEL #	(AREA CD)	EXTENSION
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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