SAFETY GROUP 430
WORKERS COMPENSATION PROGRAM

EMPLOYER'S FIRST REPORT OF INJURY

This report is to be filed directly to your Safety Group 430 representative. Please collect all the information requested by this form and report the claim as quickly as possible after medical treatment. Early reporting enables our team to begin processing the claim sooner. (Note that you do not have a claim until the claimant goes to the doctor.) Please answer completely. **Failure to fully complete the form will result in your claim not being processed by the New York State Insurance Fund.** To report a claim please call your Safety Group 430 "First Report of Injury" response line at **1-518-463-1148** or go to **www.nysada.com.**

*** *All Fields Are Required****

EMPLOYER/DEALERSHIP INFORMATION

1. Dealership Name			2. NYSIF Policy Number
3. Dealership Address			
4. City	5. Zip Code	6. Phone Number	7. Fax Number
8. Have you given the employee a Claimant Information Packet? (Yes/No)			9. If yes, when? (Date)
☐ Yes ☐ No			

EMPLOYEE'S PERSONAL INFORMATION

10. First Name	11. M.I.	12. Last Name		
13. Employee's Address				
14. City	15. State	16. Zip Code	17. Gender	18. Social Security Number
19. Employee's Telephone Number	20. Employee's Date of Birth (mm/dd/yyyy)			

EMPLOYEE'S INJURY OR ILLNESS

21. Date of Injury	22. Employee began work at: (AM/PM)	23. Time of Injury (AM/PM)
	☐ AM ☐ PM	☐ AM ☐ PM
24. Has the employee given you notice of injury/illness?		25. Date Notice was Provided
☐ Yes ☐ No		

26. If yes, notice was given to:

First Name	Last Name	Title

27. If yes, was notice given orally or in writing or both?	☐ Orally	☐ In writing	☐ Both

ACCIDENT INFORMATION

28. Where did injury/illness happen? (e.g., 1 Main St, Accident City, NY. At the front door.)

29. Was this the location where the employee normally worked? (Yes/No)

☐ Yes ☐ No

30. Employee's Supervisor's First Name	31. Employee's Supervisor's Last Name **and Title**

32. Did Supervisor see injury happen? (Yes/No/Unknown)	33. Did anyone else see the injury happen? (Yes/No/Unknown)
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

34. If yes, who witnessed the injury? (please include their title)

35. What was the employee **doing** when he/she was injured or became ill?

36. How did the injury/illness occur?

37. **Diagnosis** of Injury and All Body Parts Affected (e.g. right elbow, lower area of back, left ankle etc.)

38. 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)

☐ Yes ☐ No

39. Did the injury/illness result in the employee's death? (Yes/No)

☐ Yes ☐ No

40. Was an object involved in the injury/illness?	41. If yes, what object?
☐ Yes ☐ No	

42. Was the injury the result of the operation of a licensed motor vehicle?

☐ Yes ☐ No If yes, who owns the vehicle? ☐ Employer ☐ Employee ☐ Other

MEDICAL TREATMENT

43. Did the employee already receive treatment for this injury/illness? (Yes/No/Unknown)

☐ Yes ☐ No ☐ Unknown

44. If yes, What was the date of the employee's first medical treatment for injury/illness?

MEDICAL TREATMENT (continued)

45. Where did the employee receive first medical treatment for injury/illness?

☐ On-Site ☐ Clinic/Hospital/Urgent Care ☐ Emergency Room
☐ Doctors Office ☐ Hospital Stay Over 24 Hours ☐ Unknown

46. Who treated employee?	47. Where was employee treated? (please include address)

48. Is the employee still being treated for this injury/illness?	49. If yes, where?
☐ Yes ☐ No ☐ Unknown	

50. Address

RETURN TO WORK

51. Did employee stop work because of his/her injury/illness? (Yes/No)	52. If yes, What date?
☐ Yes ☐ No	

53. Employee's Last Day Paid	54. Has employee returned to work? (Yes/No)
	☐ Yes ☐ No

55. If yes, on what date?	56. If yes, in what capacity? (Regular Duty/Limited Duty)
	☐ Regular Duty ☐ Limited Duty

EMPLOYEE'S WORK/PAYROLL INFORMATION ON THE DATE OF THE INJURY OR ILLNESS

57. Date of hire?	58. Employee's Job Title	59. Employee's gross weekly pay

60. What types of activities did the employee normally perform at work?

61. Did employee receive lodging or tips in addition to pay? (Yes/No)	62. Employee's Job Was
☐ Yes ☐ No	☐ Full-Time ☐ Seasonal ☐ Part-Time ☐ Volunteer
63. Was the employee paid for a full day on the day of injury/illness?	
☐ Yes ☐ No	

64. Days Employee Worked	65. Employee is primarily
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	☐ Right-Handed ☐ Left-Handed

66. Did you continue to pay the employee after the injury/illness? (e.g., sick leave, vacation, disability, regular salary)

☐ Yes ☐ No

67. Please provide any additional information

68. First Name of person who provided the information	64. Last Name of person who provided the information

69. Telephone Number **& ext.**	70. Title	71. Email