OFFICE USE ONLY
❒ Information Only
❒ Medical Only
❒ Lost Time > 7 days

Claim #_____

C-2F

OSWEGO COUNTY SELF-INSURANCE PLAN
EMPLOYER'S FIRST REPORT OF WORK-RELATED INJURY/ILLNESS

A work-related injury or illness must be reported within 10 days (Section 110 of the Workers' Compensation Law) of the injury/illness or be subject to a penalty. **EMPLOYER/SUPERVISOR MUST COMPLETE (*NOT INJURED EMPLOYEE*)** and file a report for **ANY** on-the-job injury/illness regardless if it resulted in medical treatment or lost time. All questions must be answered completely. If you have questions regarding the completion or filing of this form, please contact the Oswego County Self-Insurance Plan Office at (315) 349-8285. **To submit form, please mail, fax or send electronically:**

Oswego County Self-Insurance Plan
46 East Bridge Street
Oswego, NY 13126
Fax: (315) 349-8254
E-mail: mturner@oswegocounty.com

Employee Name_____

Date of Injury_____ Time of Injury_____ Time Work/Shift Started_____

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name Oswego County Self-Insurance Plan Insurer ID W859003
Name Triad Group, LLC
Info/Attn N/A
Address 185 Jordan Road
City Troy State NY
Zip Code 12180 Country USA
Claim Admin ID T100068

EMPLOYEE INFORMATION

First Name_____ Middle Name/Initial_____

Last Name_____ Suffix_____

Mailing Address_____

City_____ State_____

Zip Code_____ Country USA

Phone Number_____ Date of Hire_____

Date of Birth_____ Gender ◯Male ◯Female

Employee SSN_____ Email Address_____

Job Title (if applicable) _____

CLAIM INFORMATION

Date Employer Had Knowledge of the Injury_____

Date Employer Had Knowledge of Date of Disability_____

Employment Status ☐Full Time ☐Part-Time ☐Seasonal ☐Volunteer ☐Other

Estimated Weekly Wage_____ Number of Days Worked Per Week_____

INJURY INFORMATION

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

Date of employee's first medical treatment?_____

Medical Provider/Facility Name (i.e. Dr. John Smith or Oswego Hospital ER)_____

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)_____

_____

_____

HOW SERIOUS WAS THE INJURY? (CHECK ONE)

☐ Did not require treatment
☐ Did not require treatment more than First Aid.
☐ Required treatment more than First Aid, but did not result in lost time.
☐ Resulted in lost time. **(MUST HAVE DOCTOR'S EXCUSE FOR ANY LOST TIME)**
☐ Restricted activity.

Death Result of Injury ◯Yes ◯No ◯Unknown Date of Death_____ Number of Dependents_____

WORK STATUS (immediately following injury/illness)

☐ No Lost Time *(if no lost time, please skip to next section)*

Last Day Worked_____ Return to Work Type ◯Actual ◯Released

Date Disability Began_____ Physical Restrictions ◯Yes ◯No

Return to Work Date_____ Return to Work Same Employer ◯Yes ◯No

ACCIDENT LOCATION AND WITNESSES

Location of Accident: ☐Employers Property ☐Lessee ☐Other

Organization Name (if applicable)_____

Street _____

City_____ State_____

Zip Code_____ Country_____USA_____

Location Narrative_____

Witnesses	Business Phone Number
_____	_____
_____	_____
_____	_____

EMPLOYER INFORMATION

Department/Municipality _____
(e.g., Oswego County Highway, Phoenix Fire Department, Town of Minetto)

Mailing Address _____

City _____ State _____

Zip Code _____ Country USA

Physical Address _____

City _____ State _____

Zip Code _____ Country USA

Contact Name _____ Phone Number _____

INSURED INFORMATION

Insured Name Oswego County Insured FEIN 15-6000463

Insured Type ☐Insured ☒**Self-Insured** ☐Uninsured Insured Location ID N/A

Policy Number ID N/A

Policy Effective Date N/A Policy Expiration Date N/A

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 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 _____