Accident Reporting – How to Complete a C-2F

The first step to accident reporting is to educate your employees about the reporting procedures. This should occur for all current employees and for any new employees. This is a requirement of PESH.

When training employees they should be advised to report injuries as soon as possible to their supervisor. At the time an employee states that they were injured at work, a C-2F "Employer's First Report of Work-Related Injury/Illness" **should be completed by a supervisor**. Always report any accident regardless of how minor. Section 110 of the Workers' Compensation Law defines reporting procedures. Section 110 states that reports shall be filed within 10 days after the occurrence of the accident. However, we strongly encourage reporting injuries/illnesses within 24-hours of their occurrence. **Penalty for late reporting is $50 or up to $2,500 additional penalty if the claimant has been disadvantaged due to late reporting.**

In the event that an employee is seriously injured (transport to hospital or out of work more than the day of injury) we ask that you immediately call the Oswego County Self-Insurance Office (Melissa Turner, (315) 349-8285) and provide the employees name, brief injury description and employees home/cell phone number.

As previously stated, the C-2F is to be completed by a supervisor or designee. A C-2F completed and/or signed by the injured employee will **NOT** be accepted. The C-2F should be completed on the computer and printed. If this is not an option, please **use black ink** when completing. Please make sure all forms are legible, completed and signed. Any forms not properly completed will be returned.

For Volunteer Fire and Ambulance Services: Please substitute "Member Name" for "Employee Name", and name of fire or ambulance service for "Employer".

Instructions for Completing Form C-2F "Employer's First Report of Work-Related Injury/Illness"

- **Employee Name** – the injured employee's **LEGAL** name
- **Date of Injury** – Date injury occurred. If the claim is for carpal tunnel, you can mark "unknown"
- **Time of Injury** – Time injury occurred
- **Time Work/Shift Started** - Time employee started working on day of injury *(For Volunteer Fire/Ambulance this would be the time the member responded to the call)*

Employee Information:

- **First Name, Middle Initial, Last Name, Suffix** – the injured employee's **full legal name**.
- **Mailing Address, City, State, Zip Code, & Country** – the full address of the injured employee.
- **Phone Number** – the employee's phone (home or cell) number including area code.
- **Date of Hire** - the date the employee was hired (month, day, year).
- **Date of Birth** – the employee's date of birth (month, day, year).
- **Gender** – check the appropriate gender.
- **Employee SSN** – the employee's Social Security Number (SSN).
- **Email address** – the employee's personal email address (in the event they are out of work and not able to access their work account)
- **Civil Service Job Title** – identify employee's job title.

Claim Information:

- **Date Employer Had Knowledge of the Injury –** the date the employer had knowledge of the injury/illness.
- **Date Employer Had Knowledge of Date of Disability –** the date the employer was notified or became aware of employee's work-related disability/incapacity (losing time due to injury).
- **Employment Status –** the applicable employment status for the employee (i.e. full time, part time, seasonal, volunteer, etc.).
- **Estimated Weekly Wage –** enter the employee's average weekly gross pay before the injury/illness.
- **Number of Days Worked Per Week –** enter the number of regularly scheduled workdays per week (1-7).

Injury Information:

- **Full Wages Paid for Date of Injury –** check "Yes" or "No" (Employer always pays full wages for the day of injury)
- **Employer Paid Salary in Lieu of Compensation –** check "Yes" or "No" to indicate if the employee continued to receive pay after the illness/injury, such as sick leave or disability pay.
- **Initial Treatment –** check the initial treatment type.
- **Date of Employee's First Medical Treatment –** indicate date the employee treated at time of injury.
- **Medical Provider/Facility Name –** indicate name of physician or facility where employee treated.
- **Nature of Injury** - indicate the type of injury (see examples below):

☐ Bruise ☐ Laceration ☐ Dislocation ☐ Fracture ☐ Puncture

☐ Sprain/Strain ☐ Burn ☐ Cut ☐ Exposure to:

- **Part of Body** – indicate the part of body that was injured (see examples below):

☐ Head ☐ Eye ☐ Ear ☐ Neck ☐ Shoulder

☐ Back ☐ Hand ☐ Arm ☐ Elbow ☐ Wrist

☐ Finger: ☐ Index ☐ Middle ☐ Ring ☐ Little Finger/Pinkie ☐ Thumb ☐ Leg

☐ Ankle ☐ Hip ☐ Knee ☐ Foot ☐ Lung(s)

- **Cause of Injury** - indicate what caused the injury (see examples below):

☐ Struck By ☐ Slip ☐ Twist ☐ Repetitive Motion ☐ Unknown

☐ Struck Against ☐ Trip ☐ Turn ☐ Lifting ☐ Push

☐ Pinch ☐ Fall ☐ Pull ☐ Bite

- **Accident/Injury Description** – describe how the accident occurred and the resulting injuries. Always begin with Employee alleges as this is the Employer's First Report of Injury, so you are reporting what the employee is telling you. *Ex. Employee alleges while exiting dump truck, slipped on step and caught self with right arm.* **BE SPECIFIC!!!!!**
- **How serious was the injury -** Check which statement most closely describes the injury.

- **Death Result of Injury –** check "Yes", "No" or "Unknown" to indicate if the injury/illness resulted in death.
- **Date of Death** – indicate the date of death, if applicable.
- **Number of Dependents** – the number of dependents, if known *(for death cases only).*

Work Status:

- If **no lost time**, check box and move on to next section.
- **Last Day Worked** – the last day worked prior to lost time.
- **Return to Work Type** – check "Actual" for employee actually returned to work, or check "Released" for employee was released to work but did not do so.
- **Date Disability Began –** first day of disability (lost time) after the 7-calendar day waiting period requirement has been met.
- **Physical Restrictions** – check "Yes" if the employee has returned to work with restrictions; check "No" if the employee has returned to work without restrictions.
- **Return to Work Date** – if the employee has returned to work, indicate the initial return to work date.
- **Return to Work Same Employer –** check "Yes" or "No".

Accident Location and Witnesses:

- **Location of Accident** – check appropriate location where injury occurred. *Employer* - accident occurred on employer's premises; *Lessee* - accident occurred on the premises of the lessee for which the employee was hired to work; or *Other* - accident occurred at a location other than the employer for which the employee was hired to work.
- **Organization Name** – the name of the organization where the injury/illness occurred.
- **Street, City, State, Zip Code, County, & Country –** the address where the injury/illness occurred.
- **Location Narrative** – provide any additional description of the location (i.e. Building C, 4th Floor in Room 101).
- **Witnesses & Business Phone Number** – indicate the names and business phone numbers of any witnesses to the injury/illness.

Employer Information:

- **Department/Municipality –** the name of municipality. Be sure to include both the municipality name and department (i.e., Town of West Monroe Highway Department)
- **Mailing Address, City, State, Zip Code, & Country –** the employer's main address where you receive mail (such as a central office). Include P.O. Boxes.
- **Physical Address, City, State, Zip Code, & Country** – the physical address of the employer (if different).

Insured Information:

- **Insured Name** – the name of the insured entity.
- **Insured FEIN** – the Insured's Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number.
- **Insured Type** – this information has been pre-filled. **Do not alter information**.
- **Insured Location ID** – N/A
- **Policy Number ID** – N/A
- **Policy Effective** – N/A
- **Policy Expiration Date** – N/A

If Prepared by Employer:

Signature of Person Preparing Form – the person who prepared the form should sign here. *The person preparing the form should not be the injured worker.*

Date – date the person who prepared the form signs the form

Print Name – printed name of the person who prepared the form. *The person preparing the form should not be the injured worker.*

Title – title of the person who prepared the form. *The person preparing the form should not be the injured worker.*

Phone Number – phone number of the person who prepared the form. *The person preparing the form should not be the injured worker.*

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