NEW YORK STATE | Workers' Compensation Board

F6483853

State of New York - Workers' Compensation Board

First Report of Injury

Report Type (MTC) UR-Upon Request (Grandfathered)

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Employee Name Jane Smith

WCB Case Number (JCN) 55555555

Date of Injury 01/01/2020

Claim Administrator Claim Number 555

Maintenance Type Code Date 01/22/2022

Claim Type N - Notification of an Incident Only

WCB Received Date 01/22/2022

Agreement to Compensate

INSURER INFORMATION

Insurer Name WCB Test Insurer

FEIN xxxxx3945

Insurer Type I - Insurer

Insurer ID W143945

CLAIM ADMINISTRATOR INFORMATION

Name WCB Test Insurer

Info/Attn

Address 328 State St.

City Schenectady

State NY

Postal Code 12305

Country

FEIN xxxxx3945

Claim Admin ID W143945

Late Reason

Claim Representative Name David Smith

Claim Representative Business Phone Number 518-555-0234

Claim Representative E-mail Address david@fcs.com

FULL DENIAL REASONS

Full Denial Reason

Denial Reason Narrative

EMPLOYEE INFORMATION

Field	Value	Field	Value
First Name	Jane	Middle Name/Initial	
Last Name	Smith	Suffix	
Mailing Address	328 State St.		
City	Schenectady	State	NY
Postal Code	12305	Country	
Phone Number	5185550234	Gender	M - Male
Date of Birth	01/02/1963	Date of Hire	04/01/2019
Employee ID Type	S - Employee Social Security Number	Employee ID	xxxxx4444
Occupation Description	Programmer		
Employee Email Address	JSmith@Fake.com		

CLAIM INFORMATION

Field	Value	Field	Value
Time of injury	18:00	Date Employer Had Knowledge of the Injury	01/01/2020
Employment Status	1 - Regular/Full-time Employee	Date Claim Administrator Had Knowledge of the Injury	01/01/2020
Wage Period	01 - Weekly	Initial Date Employer Had Knowledge of Date of Disability	
Estimated Wage	$1,050.00	Current Date Employer had Knowledge of Current Date of Disability	
Work Week Type	S - Standard Work Week	Number of Days Worked Per Week	5
Date of Denial Rescission		Work Days Scheduled (S-Scheduled N-Non Scheduled)	S M T W T F S

EMPLOYEE INJURY

Field	Value	Field	Value
Full Wages Paid for Date of Injury	Yes	Employer Paid Salary in Lieu of Compensation	
Death Result of Injury		Date of Death	
Number of Dependents			
Nature of Injury	07 - Concussion		

Part of Body

Part of Body Injured Location	Part of Body Injured	Part of Body Injured Fingers/Toes Location
	11 - Skull	
	15 - Nose	
B - Bilateral	35 - Hand	
L - Left	56 - Foot	
R - Right	38 - Shoulder(s)	
B - Bilateral	53 - Knee	
	12 - Brain	
	10 - Multiple Head Injury	
L - Left	36 - Finger(s) other than thumb	3 - Ring Finger or 3rd Toe
B - Bilateral	57 - Toes	2 - Middle Finger or 2nd Toe

Cause of Injury 30 - Fall, Slip or Trip Injury - Slip, or Trip, Did Not Fall

Type of Loss 02 - Occupational Disease

Accident/Injury Description

This is the accident description where I can type.This is the accident description where I can type.This is the accident description where I can type.This is the accident description where I can type.This is the accident description where I can type.This is the accident description where I can type.This is the accident description where I can type.This is the accident description where I can type.This is the accident description where I can type.This is the accident description where I can type.

WORK STATUS

Initial Date Last Day Worked ______

Initial Date Disability Began ______

Initial RTW Date ______

Latest RTW Type Code ______

Latest RTW/Status Date ______

Current Date Disability Began ______

Initial RTW Type Code ______

Initial RTW Physical Restrictions ______

Initial RTW With Same Employer ______

Latest RTW Physical Restrictions ______

Latest RTW With Same Employer ______

Current Date Last Day Worked ______

First Day of Disability After the Waiting Period ______

ACCIDENT LOCATION AND WITNESSES

Premises E - Employer

Organization Name

Street | **State**

City | **Postal Code**

County/Parish Unknown | **Country**

Location Narrative Unknown

Witnesses	Business Phone Number
James Halpert	5185550234

MEDICAL TREATMENT

Initial Treatment 3 - Emergency Evaluation, Diagnostic Testing, and Medical Procedures

Managed Care Org.

Managed Care Org. ID

EMPLOYER INFORMATION

Name Really Great Programmers Inc. | **Employer FEIN** xxxxx4234

Industry Code 236116 | **UI Number** 16-10000

Manual Classification 5645 - Carpentry-Detached One Or Two-Family Dwellings

Info/Attn

Mailing Address 328 State St.

City Schenectady | **State** NY

Postal Code 12305 | **Country**

Physical Addr 328 State St.

City Schenectady | **State** NY

Postal Code 12305 | **Country**

Contact Name James Halpert

Contact Business Phone Number 5185550234

INSURED INFORMATION

Insured Name Really Great Programmers Inc.

Insured FEIN xxxxx4234

Insured Type I - Insured

Insured Location ID

Policy Number ID 23423432

Policy Effective Date 01/01/2020

Policy Expiration Date