OFFICE USE ONLY		
Date Sent		
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 <u>ANY</u> 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: melissa.turner@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 Name Triad Group, LLC Info/Attn N/A	Insurer ID W859003			
Address 400 Jordan Road City Troy Zip Code 12180 Claim Admin ID T100068	State NY Country USA			
EMPLOYEE INFORMATION				
First Name	Middle Name/Initial			
Last Name_	Suffix			
Mailing Address_				
City	State			
Zip Code	CountryUSA			
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				
Estimated Weekly Wage Number of Days Worked Per Week				

INJURY INFORMATION					
Full Wages Paid for Date of Injury Yes No Emplo	yer Paid Salary in Lieu of Comper	nsation Yes No			
Initial Treatment					
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 Resulted in lost time. (MUST HAVE DOCTOR'S EXCUSE Restricted activity. Death Result of Injury Yes No Unknown Date of Deat WORK STATUS (immediately following injury/illness) No Lost Time (if no lost time, please skip to next section) Last Day Worked Date Disability Began Return to Work Date ACCIDENT LOCATION	h Number of D Return to Work Type Physical Restrictions Return to Work Same Employer	□Actual □Released □Yes □No			
Location of Accident:					
Organization Name (if applicable)					
Street					
City	State				
Zip Code	Country	USA			
Location Narrative					
Witnesses	Business Phone	e Number			

EMPLOYER INFORMATION				
Department/Municipality	Fire Department, Town of Minetto)			
Mailing Address_				
City	State			
Zip Code	CountryUSA			
Physical Address_				
City	State			
Zip Code	CountryUSA			
Contact Name	Phone Number			
INSURED INFORMATION				
Insured Name Oswego County	Insured FEIN <u>15-6000463</u>			
Insured Type	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 knowle	edge and belief.			
If prepared by the employer:				
Signature of Person Preparing Form	Date			
Print Name				
Title F	Phone Number			