EMPLOYER'S REPORT OF WORK-RELATED INJURY/ILLNESS

C-2

State of New York - Workers' Compensation Board

If one of your employees has a work-related injury or illness, you must complete and file this form **within 10 days** of the injury/illness or be subject to a penalty. For additional information on filing this form please refer to Workers' Compensation Law Section 110 at the end of this form. Type or print neatly.

WCB Case Number (if you know it): _____ Date of Injury/illness: ____/____/____

Carrier Case Number (if you know it): _____ Date of this Report: ____/____/____

A. EMPLOYER INFORMATION

1. Employer: Tender Touch Rehab 2. Employer FEIN: 26-142-8616

3. Mailing Address: Tender Touch Rehab Service 685 River Ave, Lakewood ,NJ 0870

4. Location Address (if different): _____

5. Phone Number: (732)987-3817 6. Nature of Business or Industry Code: _____

7. OSHA Case Number (if known): _____ 8. NY UI Employer Reg Number: _____

B. INSURANCE CARRIER / SELF-INSURED EMPLOYER

If individually self-insured, enter your Board W Number and skip to Section C.

1. Board W Number: **W** _____ 2. Carrier/Group Name: _____

3. Policy Number: _____ Policy Period: From: ____/____/____ To: ____/____/____

4. If Carrier Unknown, Insurance Agent Name: _____ 5. Phone Number: (____) _____

C. EMPLOYEE'S PERSONAL INFORMATION

1. Name: Balloonfightcustoms (First / MI / Last) 2.Date Of Birth ____/____/____

3. Mailing Address: G-2,GROUND FLOOR, HOUSE NO.19,SAKSHI PERADISE,BOSHANGABAD ROAD,BHOPAL,M.P

4. Social Security Number: _____ 5. Contact Phone Number: 789-993-3424 6. Gender: ☒ Male ☐ Female

D. EMPLOYEE'S INJURY OR ILLNESS

1. Time of day employee began work on date of injury: 12/10/2021-07:20 ☐ AM ☒ PM 2. Time of injury: 07:15 ☐ AM ☒ PM

3. Has the employee given you notice of injury/illness? ☒ Yes ☐ No

If yes, notice was given to: _____ ☐ orally ☒ in writing Date notice provided: ____/____/____

If available, attach a copy of the employee's written notice and medical notes, and the employer's incident report.

4. Have you given the employee a Claimant Information Packet? ☐ Yes ☐ No If yes, give date: ____/____/____

5. Where did the injury/illness happen (e.g., 1 Main St., Pottersville, at the front door):

dwdwd

6. Was this location where the employee normally worked? ☒ Yes ☐

No If no, why was the employee there? _____

7. Employee's supervisor: dwdw 8. Did supervisor see injury happen? ☒ Yes ☐ No ☐ Unknown

9. Did anyone else see the injury happen? ☐ Yes ☐ No ☐ Unknown

If yes, give name(s): _____

10. What was the employee doing when he/she was injured or became ill? (e.g., unloading a truck, stocking a shelf, typing annual report)
Walking from her car

dede

EMPLOYEE'S NAME: Balloonfightcustoms (First / MI / Last) **DATE OF INJURY/ILLNESS:** 12 / 10 / 2021

D. EMPLOYEE'S INJURY OR ILLNESS *continued*

11. How did the injury/illness occur? (e.g., the employee tripped over a pipe and fell on the floor)

dsdsssad

12. Explain fully the nature of the employee's injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead):

dwdwd

13. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ■ No If yes, what was it? _____

14. Was the injury the result of the use or operation of a licensed motor vehicle? ■ Yes ☐ No

If yes, ■ employee's vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): dwwdwdw

If employer's vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

15. Did the injury/illness result in the employee's death? ☐ Yes ■ No If yes, what was the date of death? ____/____/____

Name and address of the nearest relative:

E. MEDICAL TREATMENT

1. What was the date of the employee's first treatment? ____/____/____ None received ☐ Unknown ☐

2. Where did the employee receive first medical treatment for this injury/illness? On site ☐ Doctor's office ☐ Emergency Room ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours ☐ Unknown

Who treated the employee and where? _____

3. Is the employee still being treated for this injury/illness? ☐ Yes ☐ No ☐ Unknown

if yes, name and address to treating doctor(s):

4. 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

If yes, name the doctor(s) who treated the previous injuries/illnesses (if known):

F. RETURN TO WORK

1. Did the employee stop work because of his/her injury/illness? ☐ Yes ■ No If yes, on what date? ____/____/____

2. Has the employee returned to work? ☐ Yes ☐ No

If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty

3. If the employee has returned to limited duty, what are his/her average gross earnings per week? _____

EMPLOYEE'S NAME: Balloonfightcustoms (First / MI / Last) **DATE OF INJURY/ILLNESS:** 12 / 10 / 2021

G. EMPLOYEE'S WORK INFORMATION on the date of the injury or illness

1. Date the employee was hired: ____ / ____ / ____

2. What was the employee's job title? dsd

3. What types of activities did the employee normally perform at work? (Attach job description if available.)

dsadsd

H. EMPLOYEE'S PAYROLL INFORMATION on the date of the injury or illness

1. Employee's gross pay in an average week was: $ 0.00

2. Did the employee receive lodging or tips in addition to pay? ☐ Yes ☐ No
If yes, describe:

3. Employee's job was (check one): ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: ____

4. Which days of the week did the employee usually work? ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.

5. Was the employee paid for a full day on the day of the injury/illness? ☐ Yes ☐ No

6. Did you continue to pay the employee after the injury/illness (e.g., sick leave, vacation, disability, regular salary)? ☐ Yes ☐ No

I. ADDITIONAL INFORMATION

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 information is true to the best of my knowledge and belief.

If prepared by the employer:

Signature of Person Preparing Form: Joyce Ginsberg Date: 12 / 10 / 2021

Print Name: Joyce Ginsberg Title: Benefits Manager Phone Number: (732)987-3817

If prepared by a Third Party on Behalf of the Employer:

Signature of Person Preparing Form: ____ Date: ____ / ____ / ____

Print Name: ____ Title: ____ Phone Number: (____) ____

Company Name and Address: ____

Name & Phone Number of Person Who Provided Information Necessary to Prepare This Form: ____

Reports should be filed by sending directly to the appropriate WCB district office (DO) at the address below with a copy sent to the insurance carrier:

Albany DO - 100 Broadway-Menands, Albany NY 12241 866-750-5157 (for accidents in the following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington)
Binghamton DO - State Office Building, 44 Hawley Street, Binghamton NY13901 866-802-3604 (for accidents in the following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)
Buffalo DO - 295 Main Street, Suite 400, Buffalo NY 14203 866-211-0645 (for accidents in the following counties: Cattaraugus, Chautauqua, Erie, Niagara)
Rochester DO - 130 Main Street West, Rochester NY 14614 866-211-0644 (for accidents in the following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates)
Syracuse DO - 935 James Street, Syracuse NY 13203 866-802-3730 (for accidents in the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego,St. Lawrence)
Downstate Centralized Mailing - PO Box 5205, Binghamton NY, 13902-5205 for all DO's in NYC 800-877-1373; in Hempstead 866-805-3630; in Hauppauge 866-681-5354; in Peekskill 866-746-0552 (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)

WORKERS' COMPENSATION LAW

Section 13 Treatment and care of injured employees

(a) "The employer shall promptly provide for an injured employee such medical, surgical, optometric or other attendance or treatment, nurse and hospital service, medicine, optometric services, crutches, eye-glasses, false teeth, artificial eyes, orthotics, functional assistive and adaptive devices and apparatus for such period as the nature of injury or the process of recovery may require.****"

Section 13 Injury to employee's prosthesis

(a) "Damage to or loss of a prosthetic device shall be deemed an injury except that no disability benefits shall be payable with respect to such injury under section fifteen of this article.****"

Section 25 Effect of failure to file reports

3. (e) "If the employer or its insurance carrier fails to file a notice or report requested or required by the board or chair or otherwise required within the specified time period or within ten days if no time period is specified, the board may impose a penalty in the amount of fifty dollars.****"

Section 51 Posting of notice regarding compensation

"Every employer who has complied with section fifty of this chapter shall post and maintain in a conspicuous place or places in and about his place or places of business typewritten or printed notices in form prescribed by the chairman, stating the fact that he has complied with all the rules and regulations of the chairman and the board and that he has secured the payment of compensation to his employees and their dependents in accordance with the provisions of this chapter, but failure to post such notice as herein provided shall not in any way affect the exclusiveness of the remedy provided for by section eleven of this chapter. ****"

Section 52 Effect of failure to secure compensation

1. (a) "Failure to secure the payment of compensation shall constitute a misdemeanor, punishable by a fine of not less than five hundred nor more than two thousand five hundred dollars or imprisonment for not more than one year, or both.

(b) Where any person has previously been convicted of a failure to secure the payment of compensation within the preceding five years, upon conviction for a second violation such person shall be fined not less than one thousand nor more than five thousand dollars in addition to any other penalties including fines otherwise provided by law, and upon conviction for a third or subsequent violation such person may be fined up to seven thousand five hundred dollars in addition to any other penalties including fines otherwise provided by law.

(c) Where the employer is a corporation, the president, secretary and treasurer thereof shall be liable for failure to secure the payment of compensation under this section.****"

Section 110 Record and report of injuries by employers

1. An employer, or a third party designated by the employer, shall record any injury or illness incurred by one of its employees in the course of employment using the form prescribed by the chair for reporting injuries under subdivision two of this section. Such form, a copy of which shall be provided to the injured employee upon request, shall be maintained by the employer, or a third party designated by the employer, for at least eighteen years, and shall be subject to review by the chair at any time. Such form need not be filed with the chair unless the status of such injury or illness changes resulting in a loss of time from regular duties or in medical treatment which would require reporting in accordance with subdivision two of this section.

2. An employer, or a third party designated by the employer, shall file with the chair of the workers' compensation board and with the carrier if the employer is insured, upon a form prescribed by the chair, a report of any accident resulting in personal injury which has caused or will cause a loss of time from regular duties of one day beyond the working day or shift on which the accident occurred, or which has required or will require medical treatment beyond ordinary first aid or more than two treatments by a person rendering first aid. Such report shall state the name and nature of the business of the employer, the location of its establishment or place of work, the name, address and occupation of the injured employee, the time, nature and cause of the injury and such other information as may be required by the chair. Such report shall be filed within ten days after the occurrence of the accident. An employer shall furnish a report of an occupational disease incurred by an employee in the course of his or her employment, to the chair of the workers' compensation board, and to the carrier if the employer is insured, upon the same form. The carrier, within fourteen days of receipt of the report or accompanying the initial check forwarded to the employee, whichever is earlier, or a self-insured employer, within fourteen days of transmitting the report to the chair or accompanying the initial check forwarded to the employee, whichever is earlier, shall provide the injured employee or, in the case of death, his or her dependents with a written statement of their rights under this chapter, in a form prescribed by the chair. An employer shall file a report of any other accident resulting in personal injury incurred by its employee in the course of employment, upon the same form, whenever directed by the chair.

3. Any injury or illness which is not required to be reported in accordance with subdivision two of this section, shall not be used as a basis for determining experience modification rates, provided the employer pays in the first instance or reimburses the employer's insurer for the treatment rendered to the employee.

4. An employer who refuses or neglects to make a report or to keep records as required by this section shall be guilty of a misdemeanor, punishable by a fine of not more than one thousand dollars. The board or chair may impose a penalty of not more than two thousand five hundred dollars upon an employer who refuses or neglects to make such report.

5. The chair shall be authorized to promulgate regulations necessary to carry out the provisions of this section.

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

Please complete this form and send it directly to your local Workers' Compensation Board district office (DO). The addresses are listed at the bottom of page 3. Also send a copy of the form to your insurance carrier. If you need additional help in completing this form, you may contact the Workers' Compensation Board at **1-877-632-4996 or visit http://www.wcb.state.ny.us/.**

If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process the form. Fill out the Date of Injury/Illness, to the best of your knowledge, and the Date of this Report at the top of page 1. Remember to enter in the name of the injured employee and the date of injury/illness on the top of page 2 and page 3.

Section A - Employer Information:

Item 1: Indicate the name of the company or the owner's name and DBA name.
Item 2: Enter the employer'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.
Item 3: Enter the employer's main address where you receive mail (such as a central office). Include P.O. Boxes.
Item 4: Enter the physical address of the employer (if different).
Item 5: Enter the primary contact phone number for the employer, including area code.
Item 6: Indicate the North American Industry Classification System (NAICS) or Standard Industrial Classification (SIC) Code for your business. If you do not know your NAICS or SIC Code, please indicate the type or nature of business as accurately as possible (e.g., Restaurant, Construction, Retail).
Item 7: Enter the OSHA Case Number, if known.
Item 8: Enter the first 7 digits of your New York Unemployment Insurance (NY UI) Registration Number (UIER). This is the number used to report to the Department of Labor.

Section B - Insurance Carrier / Self-Insured Employer:

Item 1: Indicate the Carrier Code Number (**W** Number) issued by the Workers' Compensation Board. If you do not know the **W** number, contact your insurance carrier. ***If you are self-insured, only enter your Carrier Code Number (W Number) and skip to Section C.***
Item 2: Enter the name of the employer's Workers' Compensation Insurance Carrier or Group Name. If you do not know your insurance carrier, please indicate the employer's Insurance Agent Name for item 4 and the Agent's contact phone number for item 5.
Item 3: Enter your Workers' Compensation Insurance Policy Number and indicate the policy effective period for coverage at the time of the injury or illness.
Item 4: Insurance Agent Name if the carrier is unknown.
Item 5: Insurance Agent phone number, including the area code.

Section C - Employee's Personal Information:

Item 1: Indicate the injured employee's full legal name.
Item 2: Enter the employee's date of birth.
Item 3: Enter the employee's mailing address, including street number, P.O. Box (if applicable), Town or City, State, and Zip Code.
Item 4: Indicate the employee's Social Security Number (SSN).
Item 5: Enter a contact phone number for the employee, either a home phone number or a cell phone number, including the area code.
Item 6: Indicate his/her gender.

Section D - Employee's Injury or Illness:

If this is an illness or occupational disease and an exact date of illness cannot be determined, then skip items 1 and 2.
Item 1: Indicate the time of day when the employee began work on the day the injury occurred.
Item 2: Enter the time when the injury occurred.
Item 3: Check whether the employee has given notice of his/her injury or illness to the employer. If so, enter the date notice was given and if it was orally or in writing. If written notice was given, please attach a copy of the employee's notice as well as any medical notes you may have received. Also attach the [supervisor's] incident report, if available.
Item 4: Check whether you gave the employee a Claimant Information Packet and if so, when.
Item 5: Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
Item 6: Check if this was the employee's normal work location. If it was not, explain why the employee was at this location.
Item 7: Enter the name of the employee's direct supervisor.
Item 8: Indicate whether the supervisor was a witness to the injury/illness.
Item 9: Check if anyone else witnessed the injury/illness and if so, list their name(s).

Section D - Employee's Injury or Illness (cont.):

Item 10: Describe in detail what the employee was doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.

Item 11: Describe in detail how the injury/illness occurred (e.g., the employee was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.

Item 12: Indicate fully the nature and extent of the employee's injury/illness, including all body parts injured. Be as specific as possible (e.g., lumbar gluteal muscle strain resulting from sudden straining).

Item 13: Indicate if some object was involved in the accident OTHER THAN a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.

Item 14: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was the employee's, the employer's, or that of a third party and include the license plate number (if known). If the employer's vehicle was involved, fill out the automobile liability insurance carrier for the vehicle and their address.

Item 15: Check if the injury/illness resulted in the death of the employee and if so, indicate the date of death and the nearest relative of the deceased (if known).

Section E - Medical Treatment:

Item 1: If the employee did not receive medical treatment for this injury/illness, check None Received and skip to item 4. Otherwise, enter the date the employee first started treatment for this injury/illness, or check Unknown if you do not know, and complete the rest of this section.

Item 2: Check the location where initial medical treatment was administered for this injury/illness and whom was responsible for treatment/care of the employee (e.g., Physician, Nurse, EMT, etc.). Include the name of the person and the facility.

Item 3: If the employee is still receiving ongoing treatment for the same injury/illness, check Yes and indicate the name and address of the physician providing treatment; otherwise check No or Unknown.

Item 4: If the employee had a similar work-related injury to the same body part or a similar work-related illness while working for the same employer, check Yes and if known, indicate the name and address of the physician whom provided care; otherwise check No.

Section F - Return To Work:

Item 1: If the employee has stopped working as a result of the work-related injury/illness, check Yes and indicate on what date he/she stopped working.

Item 2: If the employee has since returned to work, check Yes. Also indicate on what date the employee started working again, as well as if the employee has returned to his/her Normal Duties or if the employee is on Limited or Restricted Duty. (If the employee has not returned to his/her full pre-injury or illness work duties, then the employee is on Limited Duty).

Item 3: If the employee has returned to work on Limited Duty, enter in his/her average gross earnings per week.

Section G - Employee's Work Information:

Item 1: Indicate the date the employee was hired by the employer.

Item 2: Enter the employee's current job title.

Item 3: Describe the employee's typical work activities or enter the employee's job description. If you need more space, you may attach an official job description or additional pages to completely and accurately describe the employee's work activities.

Section H - Employee's Payroll Information:

Item 1: Enter the employee's average gross weekly pay before the injury/illness.

Item 2: Check if the employee received any tips or lodging in addition to his/her regular pay and if so, describe them.

Item 3: Check the type of job the employee had.

Item 4: Check which days of the week the employee usually worked. If the employee did not work a standard work week, please explain in Section I or attach an additional page or work schedule in order to fully explain.

Item 5: Check if the employee was paid for a full day's work on the day of the injury/illness.

Item 6: Indicate if the employee continued to receive pay after the illness/injury, such as sick leave or disability pay.

Section I - Additional Information:

Enter any additional information that may be relevant to the employee's work-related injury/illness in this section. You can also use this area to further explain other items in this form, such as G-3 or H-4.

Sign Form C-2 on the last page. If the form was filled out by a third-party on behalf of the employer, that person should sign on the second signature line.