NEW YORK STATE Workers' Compensation Board

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 00-Original

F5097849

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Employee Name Jane Smith

WCB Case Number (JCN) G2687884

Date of Injury 02/02/2020

Claim Administrator Claim Number BRI-29

Maintenance Type Code Date 10/15/2020

Claim Type M - Medical Only

WCB Received Date 10/15/2020

Agreement to Compensate L - With Liability

INSURER INFORMATION

Insurer Name All American Insurance Company

FEIN xxxxx6212

Insurer Type I - Insurer

Insurer ID W212500

CLAIM ADMINISTRATOR INFORMATION

Name All American Insurance Company

Info/Attn Jane Smith

Address 12 State St

City Albany

State NY

Postal Code 12202

Country US - UNITED STATES

FEIN xxxxx6212

Claim Admin ID W212500

Late Reason

Claim Representative Name John T Doe

Claim Representative Business Phone Number 5185551212

Claim Representative E-mail Address jdoe@allamerican.com

EMPLOYEE INFORMATION

First Name Jane
Middle Name/Initial
Last Name Smith
Suffix
Mailing Address 29 Park Place
City Albany
State NY
Postal Code 12202
Country US - UNITED STATES
Phone Number 5186542323
Gender F - Female
Date of Birth 09/15/1981
Date of Hire 01/01/2018
Employee ID Type S - Employee Social Security Number
Employee ID xxxxx1212
Occupation Description

CLAIM INFORMATION

Time of injury
Date Employer Had Knowledge of the Injury 02/03/2020
Employment Status 1 - Regular/Full-time Employee
Date Claim Administrator Had Knowledge of the Injury 02/03/2020
Wage Period 01 - Weekly
Initial Date Employer Had Knowledge of Date of Disability 02/03/2020
Estimated Wage $1,200.00
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

Full Wages Paid for Date of Injury Yes
Employer Paid Salary in Lieu of Compensation No
Death Result of Injury
Date of Death
Number of Dependents
Nature of Injury 04 - Burn

Part of Body

Part of Body Injured Location	Part of Body Injured	Part of Body Injured Fingers/Toes Location
R - Right	35 - Hand	

Cause of Injury 05 - Burn or Scald - Heat or Cold Exposures - Contact With - Steam or Hot Fluids
Type of Loss 01 - Traumatic Injury
Accident/Injury Description

Spilled hot tea.

WORK STATUS

Initial Date Last Day Worked	02/02/2020	**Initial RTW Type Code**	
Initial Date Disability Began	02/03/2020	**Initial RTW Physical Restrictions**	
Initial RTW Date		**Initial RTW With Same Employer**	
Latest RTW Type Code		**Latest RTW Physical Restrictions**	
Latest RTW/Status Date		**Latest RTW With Same Employer**	
Current Date Disability Began		**Current Date Last Day Worked**	
		First Day of Disability After the Waiting Period	

ACCIDENT LOCATION AND WITNESSES

Premises E - Employer

Organization Name Mels Diner

Street	1976 Broadway	**State**	NY
City	Albany	**Postal Code**	12202
County/Parish	Albany - Albany	**Country**	US - UNITED STATES

Location Narrative Restaurant

Witnesses	**Business Phone Number**

MEDICAL TREATMENT

Initial Treatment 1 - Minor On-Site Remedies by Employer

Managed Care Org.

Managed Care Org. ID

EMPLOYER INFORMATION

Name Mel Smith

Employer FEIN xxxxx5255

Industry Code 812910

UI Number

Manual Classification 9079 - Restaurants

Info/Attn

Mailing Address 1976 Broadway

City Albany

State NY

Postal Code 12202

Country US - UNITED STATES

Physical Addr 1976 Broadway

City Albany

State NY

Postal Code 12202

Country US - UNITED STATES

Contact Name

Contact Business Phone Number

INSURED INFORMATION

Insured Name Mels Diner

Insured FEIN xxxxx2533

Insured Type S - Self-Insured

Insured Location ID

Policy Number ID

Policy Effective Date 01/01/2020

Policy Expiration Date