Workers' Compensation Board

F5098094

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) AQ-Acquired Claim

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Employee Name John T Doe

WCB Case Number (JCN) G2687908

Date of Injury 10/01/2020

Claim Administrator Claim Number VPAL137

Maintenance Type Code Date 12/10/2020

Claim Type I - Indemnity for Lost Time

WCB Received Date 12/10/2020

Agreement to Compensate L - With Liability

INSURER INFORMATION

Insurer Name All American Insurance Company

FEIN xxxxx6266

Insurer Type I - Insurer

Insurer ID W010698

CLAIM ADMINISTRATOR INFORMATION

Name All American Insurance Company

Info/Attn

Address 123 Main Street

City Albany

State NY

Postal Code 12202

Country

FEIN xxxxx5174

Claim Admin ID T100002

Late Reason

Claim Representative Name Mary Clark

Claim Representative Business Phone Number 5185185181

Claim Representative E-mail Address mclark@allamerican.com

EMPLOYEE INFORMATION

First Name John **Middle Name/Initial** T

Last Name Doe **Suffix**

Mailing Address 250 Test Street

City Rensselaer **State** NY

Postal Code 12144 **Country**

Phone Number 15185188151 **Gender** M - Male

Date of Birth 01/01/1984 **Date of Hire** 01/01/2020

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx1234

Occupation Description Carpenter

CLAIM INFORMATION

Time of injury 10:10

Employment Status 1 - Regular/Full-time Employee

Wage Period 01 - Weekly

Estimated Wage $2,300.00

Work Week Type S - Standard Work Week

Date of Denial Rescission

Date Employer Had Knowledge of the Injury 10/01/2020

Date Claim Administrator Had Knowledge of the Injury 10/01/2020

Initial Date Employer Had Knowledge of Date of Disability 10/01/2020

Current Date Employer had Knowledge of Current Date of Disability 10/01/2020

Number of Days Worked Per Week 5

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 07 - Concussion

Part of Body

Part of Body Injured Location	Part of Body Injured	Part of Body Injured Fingers/Toes Location
	12 - Brain	

Cause of Injury 25 - Fall, Slip or Trip Injury - From Different Level (Elevation)

Type of Loss 01 - Traumatic Injury

Accident/Injury Description

FALL

WORK STATUS

Initial Date Last Day Worked		**Initial RTW Type Code**	
Initial Date Disability Began	10/01/2020	**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	Great Roofing Inc.		
Street	123 Main Street	**State**	NY
City	Albany	**Postal Code**	12202
County/Parish	Albany - Albany	**Country**	
Location Narrative			

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 Jane Smith

Employer FEIN xxxxx8765

Industry Code 812910

Manual Classification 0007 - Fruit Farm & Drivers

Info/Attn

Mailing Address 123 Main Street

City Albany

State NY

Postal Code 12202

Country

Physical Addr 123 Main Street

City Albany

State NY

Postal Code 12202

Country

Contact Name Jane Smith

Contact Business Phone Number 9876678874

INSURED INFORMATION

Insured Name Great Roofing Inc.

Insured FEIN xxxxx8767

Insured Type I - Insured

Insured Location ID 987356442

Policy Number ID 7891234657

Policy Effective Date 01/01/2020

Policy Expiration Date 12/31/2020