

State of New York - Workers' Compensation Board
First Report of Injury
Report Type (MTC) AU-Acquired/Unallocated

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Employee Name John T Doe

WCB Case Number (JCN) G2688001 **Date of Injury** 02/22/2021

Claim Administrator Claim Number BRI-037 **Maintenance Type Code Date** 03/09/2021

Claim Type W - Lost Time with No Paid Indemnity **WCB Received Date** 03/09/2021

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 John T Doe

Address 12 Pine St

City Albany **State** NY

Postal Code 12202 **Country** US - UNITED STATES

FEIN xxxxx6212 **Claim Admin ID** W212500

Late Reason _____

Claim Representative Name Mary Clark

Claim Representative Business Phone Number 5185551212

Claim Representative E-mail Address mclark@allamerican.com

EMPLOYEE INFORMATION

First Name John **Middle Name/Initial** T
Last Name Doe **Suffix** _____
Mailing Address 88 Madison Ave
City Albany **State** NY
Postal Code 12202 **Country** US - UNITED STATES
Phone Number 5184435243 **Gender** M - Male
Date of Birth 09/15/1981 **Date of Hire** 01/01/2020
Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx2321
Occupation Description Writer

CLAIM INFORMATION

Time of injury 13:00 **Date Employer Had Knowledge of the Injury** 02/22/2021
Employment Status 1 - Regular/Full-time Employee **Date Claim Administrator Had Knowledge of the Injury** 02/22/2021
Wage Period 01 - Weekly **Initial Date Employer Had Knowledge of Date of Disability** 02/22/2021
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** _____
Death Result of Injury _____ **Date of Death** _____ **Number of Dependents** _____

Nature of Injury 10 - Contusion

Part of Body	Part of Body Injured Location	Part of Body Injured	Part of Body Injured Fingers/Toes Location
	L - Left	35 - Hand	

Cause of Injury 12 - Caught In, Under or Between - Object Handled

Type of Loss 01 - Traumatic Injury

Accident/Injury Description

Book dropped on hand

WORK STATUS

Initial Date Last Day Worked	<u>02/22/2021</u>	Initial RTW Type Code	_____
Initial Date Disability Began	_____	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	<u>E - Employer</u>		
Organization Name	<u>Coffee Shop</u>		
Street	<u>33 Main st</u>	State	<u>NY</u>
City	<u>Albany</u>	Postal Code	<u>12202</u>
County/Parish	<u>Albany - Albany</u>	Country	<u>US - UNITED STATES</u>
Location Narrative	<u>shop</u>		
Witnesses	Business Phone Number		
_____	_____		

MEDICAL TREATMENT

Initial Treatment	<u>1 - Minor On-Site Remedies by Employer</u>
Managed Care Org.	_____
Managed Care Org. ID	_____

EMPLOYER INFORMATION

Name Donut Shop **Employer FEIN** xxxxx6545
Industry Code 236116 **UI Number** _____
Manual Classification 2003 - Bakery & Route Salespersons, Route Supervisors, Drivers
Info/Attn _____
Mailing Address 33 main st
City Albany **State** NY
Postal Code 12202 **Country** US - UNITED STATES
Physical Addr 33 main st
City Albany **State** NY
Postal Code 12202 **Country** US - UNITED STATES
Contact Name _____
Contact Business Phone Number _____

INSURED INFORMATION

Insured Name Donut Shop **Insured FEIN** xxxxx8716
Insured Type I - Insured **Insured Location ID** _____
Policy Number ID 87454
Policy Effective Date 01/01/2020 **Policy Expiration Date** _____