

TOWN OF ROTTERDAM
REPORTING WORKERS COMPENSATION CLAIMS EFFECTIVE
04/01/2025

TOWN OF ROTTERDAM EMPLOYEE'S
REPORTING WORKERS
COMPENSATION CLAIMS

This is a prefilled form the department head must use (prefilled form) once you have typed in all the information requested then print out and department head must sign it.

When form is completed:

SEND ORIGINAL OF REPORT C 2F TO
MORGAN CORYER, Personnel and
Benefits Coordinator INTEROFFICE MAIL

Any questions call: 518 355 7575 Ext. 361



State of New York - Workers' Compensation Board
Employer's First Report of
Work-Related Injury/Illness

C-2F

A work-related injury or illness must be reported within 10 days (Per Section 110) of the injury/illness or be subject to a penalty. Employers are not required to submit form C-2F to the Workers' Compensation Board if the employer's insurer will be submitting the accident information electronically to the Board on the employer's behalf. If you need assistance completing this form, please contact your insurer for guidance on the best method of reporting work-related accident information. If you submit this form to the Board, please send it to P.O. Box 5205, Binghamton, NY 13902 and provide a copy to your insurer.

Employee Name _____

WCB Case Number (JCN) _____ Date of Injury _____

Claim Administrator Claim Number _____

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name Wright Risk Management Insurer ID W848139

Name NYS Municipal Workers Comp Alliance

Info/Attn Workers' Compensation Claims Department

Address 333 Earle Ovington Blvd., Suite 505

City Uniondale State NY

Postal Code 11553 Country USA

Claim Admin ID T100094

EMPLOYEE INFORMATION

First Name _____ Middle Name/Initial _____

Last Name _____ Suffix _____

Mailing Address _____

City _____ State _____

Postal Code _____ Country _____

Phone Number _____ Date of Hire _____

Date of Birth _____ Gender Male Female Unknown

Employee SSN _____

Occupation Description _____

CLAIM INFORMATION

Time of Injury _____ Date Employer Had Knowledge of the Injury _____
Employment Status _____ Date Employer Had Knowledge of Date of Disability _____
Estimated Weekly Wage _____ Number of Days Worked Per Week _____
Work Week Type Standard Work Week Fixed Work Week Varied Work Week
Work Days Scheduled Sun Mon Tues Wed Thurs Fri Sat

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes No Employer Paid Salary in Lieu of Compensation Yes No
Initial Treatment No Medical Treatment Minor On-Site Treatment By Employer Minor Clinic/Hospital Treatment
 Emergency Evaluation Hospitalization Greater Than 24 Hours Future Major Medical/Lost Time Anticipated
Death Result of Injury Yes No Unknown Date of Death _____ Number of Dependents _____
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) _____

WORK STATUS

Initial Date Last Day Worked _____ Return To Work Type Actual Released
Initial Date Disability Began _____ Physical Restrictions Yes No
Initial Return to Work Date _____ Return To Work Same Employer Yes No

ACCIDENT LOCATION AND WITNESSES

Premises (see instructions) Employer Lessee Other
Organization Name _____
Street _____ State _____
City _____ Postal Code _____
County _____ Country _____
Location Narrative _____
Witnesses _____ Business Phone Number _____

EMPLOYER INFORMATION

Name Town of Rotterdam Employer FEIN 146002410
UI Number _____ Manual Classification Code _____
Industry Code 92
Info/Attn Comptroller's Office
Mailing Address 1100 Sunrise Boulevard
City Schenectady State NY
Postal Code 12306 Country USA
Physical Addr 1100 Sunrise Boulevard
City Schenectady State _____
Postal Code 12306 Country _____
Contact Name Comptroller's Office
Contact Business Phone Number 518-355-7575 Ext. 361

INSURED INFORMATION

Insured Name Town of Rotterdam Insured FEIN 146002410
Insured Type Insured Self-Insured Uninsured Insured Location ID _____
Policy Number ID N/A
Policy Effective Date _____ Policy Expiration Date _____

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 _____ Date _____

Print Name _____

Title _____ Phone Number _____