

THE CITY OF NEW YORK - WORKERS' COMPENSATION CLAIM INITIATION
Supervisor's/Agency - "REPORT OF INJURY"

CLAIM NUMBER

FISA FORM WCB-120 (5/07)

(CONTINUED ON REVERSE SIDE)

INJURED EMPLOYEE NAME

SOCIAL SECURITY NUMBER

FIRST NAME M.I. LAST NAME

EMPLOYEE'S ADDRESS BORO, CITY OR TOWN STATE ZIP

DATE OF ACCIDENT / INJURY MONTH DAY YEAR TIME OF ACCIDENT HOUR MINUTE AM PM WAS EMPLOYEE ABSENT DUE TO INJURY? YES NO INITIAL ABSENCE DATE MONTH DAY YEAR INITIAL ABSENCE TIME HOUR MINUTE AM PM

TIME EMPLOYEE BEGAN WORK HOUR MINUTE AM PM

IS EMPLOYEE EXPECTED TO RETURN TO WORK? YES NO INJURED WORKER'S WORK WEEK SUN MON TUE WED THU FRI SAT (ENTER AN "X" FOR DAYS USUALLY WORKED) HAS EMPLOYEE RETURNED TO WORK? YES NO RETURN TO WORK DATE MONTH DAY YEAR

DATE SUPERVISOR NOTIFIED MONTH DAY YEAR SUPERVISOR'S FIRST NAME M.I. LAST NAME TIME NOTIFIED HOUR MINUTE AM PM TITLE (AREA CD) WORK TELEPHONE # EXTENSION

WAS ACCIDENT ON EMPLOYER'S PREMISES? YES NO DID ACCIDENT OCCUR DURING WORK HOURS? YES NO DID ACCIDENT OCCUR DURING LUNCH BREAK? YES NO WAS EMPLOYEE TRAVELING TO/FROM WORK? YES NO WAS EMPLOYEE TRAVELING BETWEEN WORK SITES? YES NO

DID ACCIDENT OCCUR AT NORMAL WORKSITE? YES NO IF NO, GIVE EXACT ACCIDENT LOCATION COUNTY

WAS EMPLOYEE ON SPECIAL OR WORK RELATED FIELD ASSIGNMENT? YES NO IF YES, DESCRIBE FIELD ASSIGNMENT

WAS INJURY WITNESSED BY SUPERVISOR? YES NO INJURY DESCRIPTION AS WITNESSED BY SUPERVISOR OR AS REPORTED MUST BE PROVIDED BELOW

CONTINUATION #1 ATTACHED

DID EMPLOYEE FOLLOW STANDARD PROCEDURES AT TIME OF ACCIDENT? YES NO IF NO, DETAILS REQUIRED

CONTINUATION #3 ATTACHED

DD EMPLOYEES ACTION OR BEHAVIOR CONTRIBUTE TO THE ACCIDENT? YES NO IF YES, DETAILS REQUIRED

CONTINUATION #4 ATTACHED

ARE DISCIPLINARY ACTIONS PENDING OR CONSIDERED AGAINST EMPLOYEE? YES NO IF YES, DETAILS REQUIRED

CONTINUATION #5 ATTACHED

DOES THE AGENCY RECOMMEND TO CONTROVERT? YES NO IF YES, DETAILS REQUIRED

CONTINUATION #6 ATTACHED

WAS MEDICAL CARE PROVIDED BY AGENCY OR MEDICAL PERSONNEL? YES NO IF YES, PROVIDE DATE & EXPLAIN MEDICAL CARE PROVIDED MONTH DAY YEAR DATE MEDICAL CARE PROVIDED

CONTINUATION #7 ATTACHED

WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? YES NO IF YES, WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? YES NO CONTINUATION #8 ATTACHED

WAS A DOCTOR / MEDICAL REPORT SUBMITTED? YES NO IF YES, PROVIDE DATE & INITIAL DIAGNOSIS MONTH DAY YEAR DOCTOR / MEDICAL REPORT DATE

CONTINUATION #9 ATTACHED

ARE YOU AWARE OF PRE-EXISTING CONDITIONS? YES NO IF YES, EXPLAIN CONDITION(S)

CONTINUATION #10 ATTACHED

DOCTOR NAME FIRST M.I. LAST ADDRESS STREET LOCATION BORO, CITY OR TOWN STATE ZIP PLUS 4

HOSPITAL NAME FIRST M.I. LAST ADDRESS STREET LOCATION BORO, CITY OR TOWN STATE ZIP PLUS 4

INJURY DESCRIPTION (SEE CODE TABLE FOR DETAILED INJURY, CAUSE & BODY PART DESCRIPTION CODE BREAKDOWN)

NATURE OF INJURY	INJURY TYPE		INJURY CODE	DESCRIPTION
	<input type="checkbox"/> SI SPECIFIC INJURY	<input type="checkbox"/> OD OCCUPATIONAL DISEASE		
CAUSE OF ACCIDENT	CAUSE CODE	CAUSE TYPE (CHECK ONE)	<input type="checkbox"/> EXPOSURE(EX) <input type="checkbox"/> FALL/SLIP(FS) <input type="checkbox"/> STRIKING AGAINST/STEP ON(SA) <input type="checkbox"/> CAUGHT BETWEEN(CB) <input type="checkbox"/> MOTOR VEHICLE(MV) <input type="checkbox"/> STRUCK INJURED(SK) <input type="checkbox"/> CUT/PUNCTURE(CP) <input type="checkbox"/> STRAIN/INJURED(SN) <input type="checkbox"/> MISCELLANEOUS CAUSE(MS)	

BODY PART(S) AFFECTED (INDICATE INJURED BODY PART CODE, DESCRIPTION AND SIDE(S) AFFECTED, IF APPLICABLE)

	BODY SECTION CODES	BODY SECTION	DESCRIPTION: (LEFT)	BODY SECTION	DESCRIPTION: (LEFT)	BODY SECTION	DESCRIPTION: (LEFT)
	HN (NECK)	PART CODE	(RIGHT)	PART CODE	(RIGHT)	PART CODE	(RIGHT)
	UE (UPPER)	PART CODE	(BOTH)	PART CODE	(BOTH)	PART CODE	(BOTH)
	TR (TRUNK)	BODY SECTION	DESCRIPTION: (LEFT)	BODY SECTION	DESCRIPTION: (LEFT)	BODY SECTION	DESCRIPTION: (LEFT)
	LE (LOWER)	PART CODE	(RIGHT)	PART CODE	(RIGHT)	PART CODE	(RIGHT)
		PART CODE	(BOTH)	PART CODE	(BOTH)	PART CODE	(BOTH)

EMPLOYEE'S JOB DESCRIPTION

JOB TASK AT TIME OF INJURY	FUNCTIONAL TITLE & DESCRIPTION	TYPICAL WORKDAY (8 HR. MAX.)	SITTING	STANDING	WALKING
			HOUR : MINUTE	HOUR : MINUTE	HOUR : MINUTE

TYPICAL WORKDAY TASKS INDICATE WORKDAY ACTIVITY %	ACTIVITY	0% (N/A)	10% (NORMAL)	20% (OCCASIONAL)	35% (MODERATE)	50% (FREQUENT)	70-100% (CONTINUOUS)
	BENDING / SQUATTING	A	B	C	D	E	F
	REACHING	A	B	C	D	E	F
	KNEELING	A	B	C	D	E	F
	REACHING ABOVE SHOULDER	A	B	C	D	E	F
	REACHING	A	B	C	D	E	F

*LIFTING	0% (N/A)	10% (NORMAL)	20% (OCCASIONAL)	35% (MODERATE)	50% (FREQUENT)	70-100% (CONTINUOUS)	
	UP TO 10 POUNDS	A	B	C	D	E	F
	11 TO 20 POUNDS	A	B	C	D	E	F
	21 TO 30 POUNDS	A	B	C	D	E	F
	31 TO 50 POUNDS	A	B	C	D	E	F
OVER 50 POUNDS	A	B	C	D	E	F	

INDICATE THE PERCENTAGE OF WEIGHT LIFTED PER CATEGORY DURING A TYPICAL WORKDAY

IS KEYBOARD USED? YES NO IF YES, HOW MANY HRS PER WEEK? ARE HANDS USED FOR NON KEYBOARD REPETITIVE MOTION? YES NO IF YES, EXPLAIN WHAT OTHER REPETITIVE MOTIONS ARE PERFORMED?

DID ACCIDENT INVOLVE A MOTOR VEHICLE? YES NO IF YES, WAS THE CITY OF NEW YORK? YES NO VEHICLE AUTHORIZED? YES NO EMPLOYEE STRUCK BY CITY VEHICLE? YES NO EMPLOYEE DRIVING A CITY VEHICLE? YES NO

WAS INJURED ON PUBLIC TRANSPORTATION? YES NO IF YES, EXPLAIN DOES EMPLOYEE OWN THE VEHICLE? YES NO CONTINUATION #12 ATTACHED WAS EMPLOYEE A VEHICLE PASSENGER? YES NO

DID EMPLOYEE DIE FROM INJURY? YES NO IF YES, ANSWER THE FOLLOWING QUESTIONS DATE EMPLOYEE DIED TIME EMPLOYEE DIED

NAME OF NEAREST RELATIVE FIRST M.I. LAST NAME RELATIONSHIP HOME TELEPHONE # ADDRESS STREET LOCATION (INCLUDE APT/FL#) BORO, CITY OR TOWN STATE ZIP PLUS 4

IDENTIFY PERTINENT DOCUMENTATION (e.g. Police Report, Safety Reports, etc.) CONTINUATION #13 ATTACHED

WAS INJURY CAUSED BY ASSAULT ON THE JOB? YES NO IF YES, PROVIDE INFORMATION BELOW ASSAULTANT WAS: CO-WORKER FRIEND, FAMILY OR ACQUAINTANCE CLIENT OTHER OFFENDER OWNER / OPERATOR OUTSIDE CONTRACTOR

ASSAULTED BY NAME OF ASSAULTANT FIRST M.I. LAST NAME ADDRESS STREET LOCATION (INCLUDE APT/FL#) BORO, CITY OR TOWN STATE ZIP PLUS 4 HOME TELEPHONE # WORK TELEPHONE # EXTENSION

CAN YOU PROVIDE DETAILED EVENTS PRECEDING ASSAULT? YES NO IF YES, EXPLAIN

DID ASSAULT INVOLVE A PERSONAL MATTER? YES NO IF YES, EXPLAIN CONTINUATION #14 ATTACHED

DID ASSAULT INVOLVE WORK RELATED MATTER? YES NO IF YES, EXPLAIN CONTINUATION #15 ATTACHED

DID THE EMPLOYEE START, PROVOKE OR PROLONG THE ASSAULT IN ANY WAY? YES NO IF YES, EXPLAIN CONTINUATION #16 ATTACHED

PREPARED BY (Please Print) SIGNATURE TITLE TEL # DATE