Bay Shore Brightwaters Rescue Ambulance, Inc.
Worker's Comp Form
3/2021

BSBRA must file a report of work-related injury or illness with NYSIF and the Workers' Compensation Board (WCB) immediately upon becoming aware of the injury or illness, and no later than 10 days after the employer's knowledge of the injury or illness. If you have been injured at BSBRA in ANY capacity, please submit a written incident report outlaying the details of the injury and fill out the form below.

We understand this is a lengthy process, however this is the information needed to submit a claim on your behalf. If you should have any questions, please contact ANY Board of Director: BOD@BSBRA.org

A. YOUR INFORMATION

1. Date of Injury: _____
2. Does Injured Worked have a SSN? If yes, please list below: _____
3. First and Last Name of Injured Worker: _____
4. Date of Birth of Injured Worker: _____
5. Phone Number of Injured Worker. Please identify if this is a cell, work, or home phone:

_____

6. What is the best time for you to be contacted? AM PM
7. Email Address of Injured Worker: _____
8. Address of Injured Worker: _____
9. Gender Identification: MALE FEMALE PREFER NOT TO ANSWER
10. Time employee began work: _____
11. Time of injury: _____
12: Did employee give notice of accident/illness? If yes, must indicate when and to whom:

_____

13. What notice of the accident given: ORALLY WRITTEN BOTH
Other: _____

B. ACCIDENT INFORMATION

14. Where did the accident/illness happen?

_____

15. Was this the location where the employee normally worked? If no, indicate why the employee was there:_____
16. First and Last Name of Employee's Supervisor: _____
17. Did Supervisor see injury happen?: YES NO UNSURE
18. Did anyone else see injury happen? YES NO UNSURE
If yes, need names and contact info:_____

19. What was employee doing when he/she was injured or became ill?:

_____

_____

_____

20. How did the injury/illness occur?

_____

_____

_____

C. INJURY INFORMATION

21. Body part(s) injured: _____

22. Cause of Injury: _____

23. Was an object involved in the injury/illness? If yes, what object?:

_____

24. Was the injury the result of the use or operation of a motor vehicle? YES NO UNSURE
If yes, was it the employee's vehicle, employer's vehicle, or other vehicle? (Please list vehicle identification #): _____

D. MEDICAL TREATEMENT INFORMATION

25. Did the employee receive treatment for this injury/illness?:

_____

26. What was the date of the employee's first treatment?: _____

27. What was the extent of medical treatment received by claimant immediately following the accident?:_____

28. Who treated the employee?: _____

29. Where was the employee treated?: _____

30. Is the employee still being treated?: YES NO UNSURE

31. Name and address of treating medical provider:

_____

E. EMPLOYMENT INFORMATION

32. Did employee stop working due to injury/illness?: YES NO

33. If YES to #32: What was employee's last date worked?: _____

34. If YES to #32: Did employee lose more than or is expected to lose more than one week of work? YES NO UNSURE

35. If YES to #32: Has employee returned to work? If yes, on what date? _____

36. If YES to #32: If employee returned to work, was it regular duty or limited duty?

_____

37. If YES to #32: If employee returned to work, was it with restrictions? _____

38. If YES to #32: If employee returned to work, was it for the same employer?_____

39. Date of Hire at BSBRA: _____

40. Job/Membership Title (Multiple Answers Allowed):-

_____

_____

41. Occupation Description:

_____

_____

42. What types of activities did claimant normally perform at work?

_____

_____

43. Employee's gross pay in an average week: _____ VOLUNTEER

44. Which days of the week did the employee usually work? What is your duty slot?:

_____

45. Last Day Paid? _____

46. Was the employee paid for a full day on the day of the injury/illness? YES NO

47. Did you submit a written incident report for this submitted claim? If yes, to whom?

_____

Member Name:_____

Member Signature:_____

Date Submitted:_____