

FIRE DEPARTMENT ● CITY OF NEW YORK

WORKERS COMPENSATION PACKAGE CHECKLIST

The following items must be included in an employee's compensation package. The complete package must be forwarded to the Bureau of Health Services, Civilian Compensation Unit, in a sealed envelope within 24 hours of injury.

Please initial the appropriate box(es):

- Health Services Referral
- Extended Leave Benefits - Medical Documentation
- Supervisor's Report of Injury/Accident to Employee
- Employee's Notice of Injury (WCD23)
- Option Election Form (DP2002)
- Employee Statement Form
- Request for LODI Benefits

Please Print

EMPLOYEE'S NAME: _____ S.S. #: _____

SUPERVISOR'S NAME: _____ S.S. #: _____

SUPERVISOR'S SIGNATURE: _____

STATION/FACILITY/BUREAU OF SUBMITTING SUPERVISOR: _____



FIRE DEPARTMENT • CITY OF NEW YORK
Bureau of Health Service Referral

Date: _____

Name: _____ Title: _____

is referred to Health Service/Emergency Department

Time Referred: _____

Supervisor (PLEASE PRINT) _____

Supervisor's Signature _____

Physician's Report

Diagnosis:

Time Employee left BHS/Emergency Room _____

Physician's Orders:

- Admitted to Hospital
- Treatment and Time off _____
- Treatment and Return to Duty
- Referred to Private Physician

Signature of Physician _____

License No _____



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EXTENDED LEAVE BENEFITS—MEDICAL DOCUMENTATION (1452)

Employee's Name: _____ S.S. #: _____

Title: _____ Date of Injury: _____

1. Nature of Injury/Illness

Work related Yes No
Aggravation of prior injury Yes No

2. Current Medical Condition

3. Aggravating Conditions

4. Medications (if applicable) Interferes with work.

 Yes No

 Yes No

 Yes No

5. Dates and Types of Treatment

6. Anticipated Length of Disability and Prognosis

7. What functions (if any) can the employee perform at work?

Physician's Name: _____ Specialty: _____

Address: _____

Phone #: _____ License #: _____ Date Report Submitted: _____

PHYSICIAN'S SIGNATURE



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SUPERVISOR'S REPORT OF OCCUPATIONAL ACCIDENT/INJURY

A. ASSIGNED WORK LOCATION OF WORKER		
FACILITY	BUREAU	ADDRESS OF WORK LOCATION

B. EMPLOYEE IDENTIFICATION				
Last Name	First Name	Sex 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	Home Phone Number Area Code ()	Date of Birth Month Day Year
Home Address (No., Street, Apt.)	City/Town	State	Zip Code	Language spoken if not English
Date of Employment Month Day Year	Job Title at time of injury	Years in current title	Social Security No.	

C. DATE, TIME AND LOCATION OF ACCIDENT/INJURY					
1. Month/Day/Year of occurrence / /	2. Time of occurrence (approx. if exact time unknown) : <input type="checkbox"/> AM <input type="checkbox"/> PM	3. Date occurrence reported month/day/year / /	4. Shift occurred <input type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Night	5. How many continuous hours worked on duty prior to this occurrence?	6. Location of Accident

D. DUTY STATUS
1. <input type="checkbox"/> On-Duty
2. <input type="checkbox"/> Off-Duty

E. OCCURRENCE CATEGORIES
1. <input type="checkbox"/> Struck by or contact with
2. <input type="checkbox"/> Caught in, on or between
3. <input type="checkbox"/> Slip, trip or fall
4. <input type="checkbox"/> Patient/visitor action
5. <input type="checkbox"/> Exposure (Airborne)
6. <input type="checkbox"/> Exposure (Bloodborne)
7. <input type="checkbox"/> Lifting, carrying, pushing or pulling
8. <input type="checkbox"/> Repetitive motion
9. <input type="checkbox"/> Other

F. CATEGORIES OF HAZARDOUS SUBSTANCES, PROCESSES OR CONDITIONS
1. <input type="checkbox"/> Mechanical equipment, tools, VDT's: _____
2. <input type="checkbox"/> Physical Hazard(s): _____
3. <input type="checkbox"/> Material Handling: _____
4. <input type="checkbox"/> Patient/Visitor Handling: _____
5. <input type="checkbox"/> Patient Care Related Equipment and Devices: _____
6. <input type="checkbox"/> Chemical(s): _____ a. <input type="checkbox"/> Solid b. <input type="checkbox"/> Liquid c. <input type="checkbox"/> Gas d. <input type="checkbox"/> Vapor/Mist e. <input type="checkbox"/> Particulates
7. <input type="checkbox"/> Metal(s): _____ a. <input type="checkbox"/> Solid b. <input type="checkbox"/> Liquid c. <input type="checkbox"/> Fumes
8. <input type="checkbox"/> Radiation: _____ a. <input type="checkbox"/> Ionizing (e.g. x-ray) b. <input type="checkbox"/> Non-ionizing (e.g. UV)
9. <input type="checkbox"/> Noise (db level if known): _____ a. <input type="checkbox"/> High Frequency b. <input type="checkbox"/> Low Frequency
10. <input type="checkbox"/> Other: _____

G. BODY PART(S) INJURED OR, EXPOSED (Check all that apply)	
1. <input type="checkbox"/> Head	3. <input type="checkbox"/> Nose
2. <input type="checkbox"/> Eye	4. <input type="checkbox"/> Mouth
	5. <input type="checkbox"/> Neck
6. <input type="checkbox"/> Shoulder	8. <input type="checkbox"/> Arm
7. <input type="checkbox"/> Chest	9. <input type="checkbox"/> Back
10. <input type="checkbox"/> Stomach	
11. <input type="checkbox"/> Pelvis	12. <input type="checkbox"/> Wrist
15. <input type="checkbox"/> Buttocks	13. <input type="checkbox"/> Hand
16. <input type="checkbox"/> Thigh	14. <input type="checkbox"/> Digit
17. <input type="checkbox"/> Knee	SIDE OF BODY <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Other
18. <input type="checkbox"/> Lower Leg	19. <input type="checkbox"/> Ankle
21. <input type="checkbox"/> Toe	20. <input type="checkbox"/> Foot
22. <input type="checkbox"/> Other: _____	

CITY OF NEW YORK

WCD 23 (R84)

EMPLOYEE'S NOTICE OF INJURY
(Pursuant to § 18 of the Worker's Compensation Law)

FORWARD TO: LAW DEPARTMENT, WORKER'S COMPENSATION DIVISION

350 Jay Street, 9th Floor, Brooklyn, NY 11201

(TOGETHER WITH C2 WHEN POSSIBLE)

ANSWER ALL QUESTIONS FULLY. THIS IS YOUR NOTICE TO YOUR EMPLOYER OF INJURY ON THE JOB. PRINT OR WRITE LEGIBLY.

1. Full name of injured person
(First) (Middle) (Last)

2. Address

Home Tel. No. Business Tel. No.

Employee's S.S. No. Date of Birth

3. Name of employer CITY OF NEW YORK – DEPARTMENT OF

4. Date of accidentHour.....AM.....PM

5. Exact location where accident happened

6. How did accident happen? (describe fully)

7. Nature and extent of injury

8. Did you inform your superior of this accident? Date?

Name such person

9. Names and addresses of witnesses

Dated19

(Sign here)

THIS IS NOT A CLAIM FORM. A CLAIM FORM MAY BE SECURED AT ANY OFFICE OF THE STATE WORKERS' COMPENSATION BOARD

THE CITY OF NEW YORK

Election of Rate Of Charge Against Annual and/or Sick Leave Balances
for Absence Due To Injury Sustained in the Performance of Official Duties

(Pursuant to Regulation 7.0 of the Leave Regulations for employees who are under the Career and Salary Plan)

INSTRUCTIONS: The injured employee, or an authorized person acting in his behalf, should submit this election notice (in duplicate) to the head of his department or agency within the first seven calendar days of absence due to injury sustained in the performance of official duties.

I, _____, employed in _____,
(Print name of injured employee) (Print name of city department of agency)

in a position which is subject to the Leave Regulations for employees who are under the Career and Salary Plan, or my authorized agent, do hereby elect the option designated below, subject to the conditions attached thereto, as the one to be applied in determining the charge, if any, to be made against my annual and/or sick leave balances for absence due to injury sustained in the performance of my official duties:

(Check one option only)

OPTION 1: I elect to receive the difference between the amount of my weekly salary and the compensation rate, subject to the following conditions:

- (a) A pro-rated charge shall be made against my sick leave and/or annual leave balances equal to the number of working days of absence less the number of working days represented by the Worker's Compensation payments, and;
- (b) My accrued sick leave and/or annual leave balances, or such leave credits advanced to me in accordance with the Career and Salary Plan Leave Regulations, are adequate to meet the charges made against them for supplementary pay, and;
- (c) The injury sustained by me was not the result of my willful gross disobedience of safety rules or my willful failure to use a safety device, nor was I under the influence of alcohol or narcotics at the time of injury, nor did I willfully intend to bring about injury or death upon myself or another, and;
- (d) Such medical examinations will be undergone by me as are requested by the Worker's Compensation Division of the Law Department and my agency, and when found fit for duty by said physicians, I shall return to my employment.

OPTION 2: I elect to receive Worker's Compensation benefits in their entirety with no charge against sick and/or annual leave.

Injured employee's signature	Date
This shaded section should be completed only if the injured employee cannot sign and must designate an authorized person to sign in his behalf	Authorized designee's name (print)
	Relationship to injured employee
	Authorized designee's address
	Authorized designee's signature
	Date
Witness's name (print)	
Witness's address	



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REQUEST FOR LODI BENEFITS

This form, upon receipt and review, will be signed by the Executive Director, or designee, and returned to the member of Service.

1. I, _____, stationed at _____, do hereby request LODI benefits subject to the conditions below, for absences due to the following injury/injuries:

- a) The injuries that I sustained were not the result of my negligence, or failure to use safety devices, nor was I under the influence of alcohol or illicit drugs at the time of injury.
b) I will undergo such medical examinations as requested by the Bureau of Health Services and when found fit for limited or full duty, I shall return to my employment.
c) I understand that my benefits are subject to approval of the Fire Commissioner or designee, and that it is my responsibility to submit regular medical proof of my disability to the Civilian Compensation Unit.
d) Benefits provided pursuant to this agreement shall be in addition to but not concurrent with benefits provided under 7.0 & 7.1 of the Leave Regulations.
e) I understand that in order to receive LODI Benefits, I am subject to telephone calls and/or mandated home visits to verify compliance with Operating Guide Procedure #125-2.
f) I shall notify the Fire Department, EMS Communications Notification Desk when I will not be at my place of recuperation during 0800 to 1600 hours, Monday thru Friday except for Department holidays, and indicate the reason for my absence.

2. I do not wish to receive LODI Benefits for this injury. I am aware that this request is irrevocable.

SIGNATURE OF MEMBER DATE
TITLE SOCIAL SECURITY NUMBER

A copy of this form shall be retained by the employee.

FOR CIVILIAN COMPENSATION UNIT USE ONLY!

LODI Benefits: [] Approved [] Disapproved [] Pending [] Not Requested By Employee [] No Time Lost Injury

cc: Station Commander

ADMINISTRATIVE SIGNATURE

