

C-2 (5-53)

WORKMEN'S COMPENSATION BOARD
State of New York

EMPLOYER'S REPORT
OF INJURY

Send this notice directly to Chairman, Workmen's Compensation Board at address shown on reverse side within ten (10) days after accident occurs. Copy also should be sent to your insurance carrier.

W. C. B. CASE NO.	CARRIER'S CASE NO. AND CODE NO.	DATE OF ACCIDENT
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(The spaces above not to be filled in by employer)

1. EMPLOYER	NAME	ADDRESS
2. INSURANCE CARRIER	Mundet Cork Corporation	1800 Broadway, Buffalo 12, N.Y.
3. INJURED PERSON	The Aetna Casualty & Surety Company Claim Dept., Genesee Bldg. Buffalo 2, N. Y. Russell L. CLARK (First Name) (Middle Initial) (Last Name)	EMPLOYEE'S S. S. ACCT. NO. 115-05-5008 35 Walnut St., W. Seneca, N.Y. (Home Address)

4. Nature of business: (State principal products manufactured or sold or services rendered)
Insulation Contractors & Distributors

5. Place where accident occurred: Bethlehem Steel Company
6. Date of accident: Oct. 19, 1961 Day of Week Thurs. Hour of Day 8:35 A. M. P. M.
7. (a) Date disability began: 1961 Day of Week Thurs. Hour of Day 8:35 A. M. P. M.
(b) Was injured paid in full for this day? yes
8. Name of foreman: Earl Spicer
9. When did you or foreman first know of injury? same day
10. Names and addresses of witnesses:

ACCIDENT

11. (a) Marital status: married (b) Sex: male
12. Age: 40 13. Did you have on file employment certificate or permit?
14. Occupation: (a) Job title for which employed: Asbestos Worker
(b) Occupation when injured: same
15. (a) How long employed by you? (b) Piece or time worker?
16. (c) Hours per day: (d) Days per week: (e) Earnings in your employ: (a) Rate per: Hour \$ Day \$ Week \$ Month \$
(b) Total earnings paid during year prior to date of accident: (include bonuses paid, value of board, lodging, etc.) \$
(c) Bonuses or premiums paid and included in item 16 (b) above: \$ Average per week: \$ (d) Estimated value of board, lodging, or other advantages in addition to wages: (included in item 16 (b) above) \$
(e) Calendar weeks in past 52 in same kind of work as at time of injury:

INJURED PERSON

17. State nature of injury and part or parts of body affected: (as "Injury to Chest," etc.)
Chest back

NATURE OF INJURY OR OCCUPATIONAL DISEASE

18. Did you provide medical care? yes If so, when? at time of accident
19. Name and address of physician: Bethlehem Steel Clinic
20. Name and address of hospital:
21. Probable length of disability: yes
22. (a) Has employee returned to work? yes (b) If so, give date: same day
(c) At what occupation? (d) At what weekly wage? \$

NOTE: Form C-11 must be filed each time there is any change in the employment status as reported in item 22 above.

FATAL CASES

23. Has injured died? (a) If so, give date of death:
- (b) Name and address of nearest relative:
24. (a) What was employee doing when accident occurred? (Describe briefly as "loading truck," "operating press," "shoveling dirt," "painting with spray gun," "walking downstairs," etc.)
cutting block

CAUSE OF ACCIDENT OR OCCUPATIONAL DISEASE

- (b) Where did accident occur? (Specify street, factory yard, on loading platform, in factory, etc.)
31 Wasco Street between 1st and 2nd
25. How was accident or occupational disease sustained? (Describe fully, stating whether injured person slipped, fell, was struck, etc., and what factors led up to or contributed to accident. Use additional sheets, if necessary.)
26. (a) What specific machine, tool, appliance, gas, liquid, or other substance or object was most closely connected with this accident or occupational disease?
(b) If mechanical apparatus or vehicle, what part of it? (State if gears, pulley, motor, etc.)
27. Were mechanical guards or other safeguards (such as ropes) provided? (a) Were they in

INSTRUCTIONS TO EMPLOYERS

Accident reports should be sent directly to the district offices at these addresses:

ALBANY (4)—1949 North Broadway. For all accidents in the following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington.

BINGHAMTON—221 Washington Street. For all accidents in the following counties: Broome, Chenango, Cortland, Delaware, Otsego, Sullivan, Tioga, Tompkins.

BUFFALO (2)—210 Franklin Street. For all accidents in the following counties: Cattaraugus, Chautauqua, Erie, Niagara.

NEW YORK CITY (13)—80 Centre Street. For all accidents in following counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, Westchester.

ROCHESTER (14)—155 Main Street West. For all accidents in following counties: Allegany, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates.

SYRACUSE (2)—214 South Warren Street. For all accidents in following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence.

WORKMEN'S COMPENSATION LAW

Sec. 13. Treatment and care of injured employees.

"The employer shall promptly provide for an injured employee such medical, surgical or other attendance or treatment, nurse and hospital service, medicine, crutches and apparatus for such period as the nature of the injury or the process of recovery may require. ****"

Sec. 51. Posting of notice regarding compensation.

"Every employer who has complied with section fifty of this chapter shall post and maintain in a conspicuous place or places in and about his place or places of business typewritten or printed notices in form prescribed by the chairman, stating the fact that he has complied with all the rules and regulations of the chairman and the board and that he has secured the payment of compensation to his employees and their dependents in accordance with the provisions of this chapter, but failure to post such notice as herein provided shall not in any way affect the exclusiveness of the remedy provided for by section eleven of this chapter. ****"

Sec. 52. Effect of failure to secure compensation.

"Failure to secure the payment of compensation shall constitute a misdemeanor, punishable by a fine of not more than five hundred dollars or imprisonment for not more than one year, or both. Where the employer is a corporation the president, secretary and treasurer thereof shall be liable for failure to secure the payment of compensation under this section. ****"

Sec. 110. Record and report of injuries by employers.

"Every employer shall keep a record of all injuries, fatal or otherwise, received by his employees in the course of their employment. Within ten days after the occurrence of an accident resulting in personal injury, which shall cause a loss of time from regular duties beyond the working day or shift on which the accident occurred, or which shall require medical treatment beyond ordinary first aid or more than two treatments by a physician or person rendering first aid, a report thereof shall be made in writing by the employer to the chairman of the workmen's compensation board upon blanks to be procured from the chairman for that purpose. Such report shall state the name and nature of the business of the employer, the location of his establishment or place of work, the name, address and occupation of the injured employee, the time, nature and cause of the injury and such other information as may be required by the chairman. An employer shall furnish a report of any other accident resulting in an injury received by an employee in the course of his employment or an occupational disease incurred by an employee in the course of his employment whenever directed by the chairman. With the approval of the chairman an employer may report upon a single report form, in such detail as may be required by the chairman, all injuries to his employees within any calendar month which have caused either no loss of time or in which the employees have returned to their regular employment at their regular wages after not more than three days if there is no evidence of further disability and there is no indication for further treatment. Every such

WORKMEN'S COMP.

BOARD

STATE OF NEW YORK

EMPLOYER'S REPORT OF INJURY

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1. EMPLOYER	NAME				ADDRESS	
2. INSURANCE CARRIER	THE AETNA CASUALTY and SURETY COMPANY CLAIM DEPARTMENT, GENESEE BUILDING, BUFFALO 2, N. Y.					
3. INJURED PERSON	ELLS ELL (First Name)	L (Middle Initial)	C / A R K (Last Name)	35 WYATT ST (Home Address)	115-05-5008 EMPLOYER'S S. S. ACCT. NO.	DATE OF ACCIDENT

4. Nature of business: (State principal products manufactured or sold or services rendered).

5. Place where accident occurred:

6. Date of accident: 10 19 1961 Day of Week Thurs Hour of Day 1330 A. M. P. M.
7. (a) Date disability began: _____ 19____, _____ Hour of Day _____ A. M. P. M.

7. (a) Date disability began: _____ 19____, _____
Hour of Day _____ A. M. _____ P. M.

ACCIDENT

8. Name of foreman W. Green
9. When did you or foreman first know of injury? 2 days ago
10. Names and addresses of witnesses: _____

11. (a) Marital status: MARRIED (b) Sex MALE
12. Age: 40 13. Did you have on file employment certificate or permit?
14. Occupation: (a) Job title for which employed: SEALER WORKER

15. (a) How long employed by you? _____ (b) Piece or time worker? _____
(c) Hours per day: _____ (d) Days per week: _____

**INJURED
PERSON**

16. Earnings in your employ: (a) Rate per: Hour \$ _____ Day \$ _____ Week \$ _____ Month \$ _____
 (b) Total earnings paid during year prior to date of accident: (include bonuses paid, value of board, lodging, etc.) \$ _____ Average per week: \$ _____ (d) Estimated value of board, lodging, or other advantages in addition to wages: (included in item 16(b) above) \$ _____

(e) Calendar weeks in past 52 in same kind of work as at time of injury:

17. State nature of injury and part or parts of body affected: (as "Injury to Chest," etc.)

NATURE OF

18. Did you provide medical care? YES If so, when? at time of Acc.

19. Name and address of physician: _____

20. Name and address of hospital: St. Lukes Hospital St. Louis

21. Probable length of disability: 1

22. (a) Has employee returned to work? YES (b) If so, give date: same

(c) At what occupation? 5 + 10 hr (d) At what weekly wage? \$

NOTE: Form C-11 must be filed each time there is any change in the employment status as reported in item 22 above.

23. Has injured died? (a) If so, give date of death: _____

(b) Name and address of nearest relative: _____

24. (a) What was employee doing when accident occurred? (Describe briefly as "loading truck," "operating press," "shoveling dirt," "painting with spray gun," "walking downstairs," etc.)

(b) Where did accident occur? (Specify whether in street, factory yard, on loading platform, in factory, etc.)

CAUSE OF

25. How was accident or occupational disease sustained? (Describe fully, stating whether injured person slipped, fell, was struck, etc., and what factors led up to or contributed to accident. Use additional sheets, if necessary.)

OCCUPA-

26. (a) What specific machine, tool, appliance, gas, liquid, or other substance or object was most closely connected with this accident or occupational disease?

(b) If mechanical apparatus or vehicle, what part of it? (State if gears, pulley, motor, etc.)

27. Were mechanical guards or other safeguards (such as goggles) provided? _____ (a) Were they in use at time of accident? _____ (b) Was machine, tool, or object defective? _____ If so, in what way? _____

Enter "X" in this box if accident was re-

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SYRACUSE (2)—State Office Building. For all injuries in following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence.

WORKMEN'S COMPENSATION LAW

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