SIF INTAKE FORM

Attachment: C

Part of Body Injured

Check here if claimant:
a) ☐ is "Annual Salaried"
b) ☐ is subject to the NYS Time and Attendance Rules

CLAIMS MEDICAL DEPARTMENT INITIAL TELEPHONE INQUIRY NYS CASE

1. Case No.	Claimant	Date of Accident	Employer
2. Home Address			
3. Reporter's Name		Title	
4. Facility's Address and Code No.		Telephone No.	
		5. N.U.	5a. Pass days
6. Has Claimant returned to work? ☐ No ☐ Yes If yes, date			
7. Notice given to	Title	Date	
8. Social Security Number	Date of Birth	Home Phone No.	
9a. Title/Occupation	b. How Long Employed?	c. Gross wages per week	
10. Days worked per week	Last day worked	Last day paid	
11. Doctor/Hospital			

ANSWER QUESTIONS 12 - 14 *ONLY* IF THERE IS LOST TIME

12. Is the employee charging any leave credits during the first seven calendar days after the accident? ☐ No ☐ Yes
If yes, how many days will be charged?

13. Prior conditions - accidents, operations, congenital conditions

a. Are any of these conditions due to compensation cases? ☐ Yes ☐ No Was SIF Carrier? ☐ Yes ☐ No

b. Explain

14. Third Party (Name and Address), if none state "None"

15. Location of Accident (include street address, city, town or village)

16. History of Accident/Remarks: (Include job description if title is not self-explanatory and there is lost time)

Print Name	Title	
Signature	Telephone No.	Date

Use Reverse Side for Added Remarks - Make Sure to Tumble Head Sheet

C-142.15 (11/86)

NYS DCS ERS 5/93