SIF INTAKE FORM

EXHIBIT 2

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 & code No.:..... Phone No.: .....

5. Neg. Unit . 5a. Pass days .....

6. Has claimant returned to work?..... Date of return:.....

7. Notice given to:..... Title: ..... Date: ....

8. Social Security No.:..... Date of Birth..... Home Phone# .....

9. Title/Occupation:..... How long employed: .....

Gross wages:..... Per week

10. Days worked per week:..... Last Day Worked..... Last Day Paid .....

11. Doctor/Hospital .....

ASK 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?..... WAS SIF CARRIER? .....

b. Explain.....

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

HISTORY OF ACCIDENT/REMARKS: - (Include job description if title is not self-explanatory and there is lost t

.....

.....

.....Print Name.....Telephone Number.....

Date:..... Signature ..... Title .....

C-142.1S (11/86) Use reverse side for added remarks--make sure to tumble head sheet