THE CITY OF NEW YORK

WORKERS' COMPENSATION CLAIM INITIATION

EMPLOYEE STATEMENT

FISA FORM WCS-110 (1/01)

CLAIM NUMBER

INJURED EMPLOYEE NAME

FIRST NAME | M.I. | LAST NAME

SOCIAL SECURITY NUMBER

EMPLOYEE'S ADDRESS

STREET LOCATION | APT #, FL.#, BOX #

BORO, CITY OR TOWN | STATE | ZIP

DATE OF ACCIDENT / INJURY MM-DD-YYYY

TIME OF ACCIDENT HH:MM AM ☐ PM ☐

WORK TEL # (AREA CD) EXTENSION

HOME TEL # (AREA CD)

DATE OF STATEMENT MM-DD-YYYY

OF WITNESS(ES)

SUPERIOR NOTIFIED

FIRST NAME | M.I. | LAST NAME | DATE FIRST NOTIFIED MM-DD-YYYY

TITLE

WORK TEL # (AREA CD) EXTENSION

DESCRIBE LOCATION WHERE ACCIDENT OCCURRED

☐ CONTINUATION #1 ATTACHED

DESCRIBE FULLY HOW ACCIDENT OCCURRED

☐ CONTINUATION #2 ATTACHED

DESCRIBE OBJECT OR SUBSTANCE THAT CAUSED INJURY

☐ CONTINUATION #3 ATTACHED

DESCRIBE NATURE AND EXTENT OF INJURY (INCLUDING AFFECTED BODY PARTS)

☐ CONTINUATION #4 ATTACHED

NAME (PLEASE PRINT) | TITLE | TEL.#

SIGNATURE | DATE