

Broome County Office of Risk & Insurance Management

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ADMINISTRATION REPORT / WORKERS' COMPENSATION

To be filled out by Payroll Contact in Department

All fields must be completed to comply with New York State Compensation Forms

ADDITIONAL INFORMATION

Name: _____
 First Middle Last Social Security No

Address: _____
 Street Address City State Zip Code

Home Phone No. _____ Date of Birth: _____ Age: _____ Sex: _____

Job Title: _____ Date of hire: _____

Employee's Average Weekly Wage: _____
(required to calculate employee benefits)

<input type="checkbox"/>	Full time	Usual	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Varies
<input type="checkbox"/>	Part time	Work Week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Work Status and Payment Information

Date of accident: _____ First date out of work per **Doctor's note** _____

Is the employee using benefit time to cover lost days? Yes No

If yes, when will the employee run out of benefit time? _____

Date of return to work: _____

Person to contact: _____ Phone Number: _____
 Name and Title