WCD-23(R84)

THE CITY OF NEW YORK
EMPLOYEE'S NOTICE OF INJURY
(PURSUANT TO § 18 OF WORKERS' COMPENSATION LAW)

LAW DEPARTMENT, WORKERS' COMPENSATION DIVISION
350 JAY STREET, BROOKLYN, NY 11201-9TH FLOOR

(TOGETHER WITH C-2 WHEN POSSIBLE)

ANSWER ALL QUESTIONS FULLY. THIS IS YOUR NOTICE TO YOUR EMPLOYER OF INJURY ON THE JOB. PRINT OR TYPE LEGIBLY.

1. Full name of injured person_____
   (First) (Middle) (Last)
2. Address_____

   Home Tel. No._____ Business Tel. No._____

   Employee's S.S. No._____ Date of Birth_____

3. Name of Employer _____ Department of_____

4. Date of Accident_____Hour_____AM_____PM_____
5. Exact location where accident happened_____

   _____

6. How did accident happen? (describe fully)_____

   _____

   _____

   _____

7. Nature and extent of injury _____

   _____

   _____

8. Did you inform your supervisor of this accident?_____Date_____

   Name such person _____

9. Names and addresses of witnesses_____

   _____

Dated_____ Sign Here_____

THIS IS NOT A CLAIM FORM. A CLAIM FORM MAY BE SECURED AT ANY OFFICE OF THE STATE WORKERS' COMPENSATION BOARD.