STATE OF NEW YORK-WORKERS' COMPENSATION BOARD

POLITICAL SUBDIVISION'S REPORT OF INJURY TO VOLUNTEER FIREFIGHTER

Send this Report directly to Chair, Workers' Compensation Board at address shown on reverse side within ten (10) days after injury is incurred. Answer all questions fully. Copy also should be provided to or retained by your insurance carrier.

Any political subdivision that fails to timely file Form VF-2, as required by Section 110 of the Workers' Compensation Law and Section 42 of the Volunteer Firefighters' Benefit Law, shall be subject to a fine of not more than $1,000. In addition, the Board or Chair may impose a penalty of up to $2,500.

TYPEWRITER PREPARATION IS STRONGLY RECOMMENDED - INCLUDE ZIP CODE IN ALL ADDRESSES-VOLUNTEER FIREFIGHTER'S S.S.NO. MUST BE ENTERED BELOW

WCB CASE NO.(If Known)	CARRIER CASE NO.	CARRIER CODE NO.	VF POLICY NO.	SOCIAL SECURITY NO.
		W-815005		

	NAME	ADDRESS
1. POLITICAL SUBDIVISION OR FIRE DISTRICT		
2. FIRE COMPANY		
3. INSURANCE CARRIER IF ANY		

INJURED PERSON

4.NAME AND ADDRESS OF VOLUNTEER FIREFIGHTER

5.(a) SEX

5.(b) DATE OF BIRTH month day year

6.NAME AND ADDRESS OF REGULAR EMPLOYER

7. HAS INJURED FIREFIGHTER RETURNED TO REGULAR EMPLOYMENT ☐ Yes ☐ No

INJURY

8. WHERE DID INJURY OCCUR? (Specify in building, outside building, en route in fire truck, etc.)

9. CHECK ONE: ☐ THE ABOVE-NAMED VOLUNTEER FIREFIGHTER WAS INJURED IN THE LINE OF DUTY WHILE SERVING WITH HIS/HER OWN FIRE COMPANY OR FIRE DEPARTMENT. ☐ THE ABOVE-NAMED VOLUNTEER FIREFIGHTER, MEMBER OF ANOTHER FIRE DEPARTMENT, WAS INJURED IN LINE OF DUTY AFTER HIS/HER SERVICES HAD BEEN ACCEPTED BY THE ABOVE-NAMED FIRE COMPANY OR FIRE DEPARTMENT.

10. DATE OF INJURY

11. DATE DISABILITY BEGAN

12. DATE OF FIRST KNOWLEDGE OF INJURY

13. WAS NOTICE OF INJURY GIVEN IN WRITING ☐ Yes ☐ No

14. ADDRESS WHERE INJURY OCCURRED

15. NAMES AND ADDRESSES OF WITNESSES (Attach separate sheet if necessary.)

16. NATURE OF INJURY AND PART(S) OF BODY AFFECTED: (e.g., "INJURY TO CHEST", etc.)

17. DID YOU PROVIDE MEDICAL CARE? ☐ Ye ☐ No IF YES, WHEN

18. (a) NAME AND ADDRESS OF DOCTOR

(b) NAME AND ADDRESS OF HOSPITAL

CAUSE OF INJURY

19. WHAT WAS FIREFIGHTER DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material firefighter was using.)

20. HOW DID THE INJURY OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)

21. (a) WAS PROTECTIVE EQUIPMENT PROVIDED. (Such as gas mask, etc.) ☐ Yes ☐ No (b) WAS PROTECTIVE EQUIPMENT IN USE AT THE TIME? ☐ Yes ☐ No

(c) WAS PROTECTIVE EQUIPMENT DEFECTIVE? ☐ Yes ☐ No S, IN WHAT WAY (Attach separate sheet if necessary).

FATAL CASES

22. (a) DATE OF DEATH

(b) NAME AND ADDRESS OF NEAREST RELATIVE

(c) RELATIONSHIP

PREPARATION

DATE OF THIS REPORT

IF FORM IS SUBMITTED BY POLITICAL SUBDIVISION, COMPLETE A & B BELOW.
IF FORM IS SUBMITTED BY THIRD PARTY, COMPLETE A,B,C & D BELOW.

A. PERSON PREPARING FORM OR SUPPLYING INFORMATION TO THIRD PARTY

B. TITLE

TELEPHONE NUMBER & EXTENSION

C. IF REPORT PREPARED BY THIRD PARTY, COMPANY NAME AND ADDRESS

D. THIRD PARTY CONTACT NAME

TELEPHONE NUMBER & EXTENSION

* Contact phone # :