NYSIF Electronic First Report of Injury (eFROI) Worksheet

- Please use this completed worksheet to help file your claim online at www.nysif.com.
- Fields in **BOLD** are required to complete the claim online.
- Do not forget to give the injured employee a Claimant Information Packet.

Policyholder Information		
Policyholder Name:		
Policy Number:	**Industry Type Code**:	**Phone**:
Policyholder Mailing Address:		
City:	**State**:	**ZIP Code**:

Claimant Information		
Claimant Name:		
Claimant Address:		
City:	**State**:	**ZIP Code**:
Phone:	SSN:	**Date of Birth**:
Gender:	Job Title:	
Did Employee give notice of accident/illness? ☐ **YES** ☐ **NO**	**If so, to whom?**	
Injured Employee's Supervisor's name:		

Employment Information	
Date of Hire:	**Claimant's Gross Average Weekly Wage**:
Claimant's usual days worked:	Time claimant started work on date of incident:
Date claimant stopped working (due to injury):	**Last day paid, if lost time case**:
What was the first scheduled work day/work shift they missed after the accident?	**Is employer continuing to pay claimant while out?** ☐ **YES** ☐ **NO**
Has claimant returned to work (RTW)? ☐ **YES** ☐ **NO**	**If yes (RTW), the date they returned to work:**
If claimant RTW, are there any restrictions?	
Has employer provided the Claimant Information Packet (CIP): ☐ **YES** ☐ **NO**	**If yes, what date was the CIP provided?**

Accident/Illness and Injury Information	
Date and time of accident/illness or injury:	**Where did the accident/illness happen?**
What was the employee doing at the time of injury?	
How did the accident occur?	
Is the accident location the same as the policy location?: ☐ **YES** ☐ **NO**	
If not, what is the accident address location?	
Did the accident occur where the employee normally worked?: ☐ **YES** ☐ **NO**	
If not, why was he/she there?	
Nature of the injury (such as "Laceration" or "Fracture"):	
Body part(s) injured (up to six body parts may be selected):	
Cause of Injury:	**Type of Loss:**
To your knowledge, did the employee have another work-related injury to the same body part or similar illness while working for you: ☐ **YES** ☐ **NO**	
Did the injury/illness result in the employee's death?: ☐ **YES** ☐ **NO**	
Was an object involved in the injury/illness?: ☐ **YES** ☐ **NO**	
Was the injury the result of the use or operation of a licensed motor vehicle?: ☐ **YES** ☐ **NO**	
Please include auto insurance information if accident involved employer's motor vehicle. (carrier, policy #, etc.):	

<table>
<tr><th colspan="6">ACCIDENT/ILLNESS AND INJURY INFORMATION (CONT.)</th></tr>
<tr><td colspan="6">When did the employer become aware that the employee’s lost time was due to injury/illness?</td></tr>
<tr><td colspan="6">Did the claimant’s supervisor see the injury? ☐ YES ☐ NO</td></tr>
<tr><td colspan="6">Any other witnesses to the injury?</td></tr>
<tr><td colspan="6">What was the claimant doing when injured?</td></tr>
<tr><td colspan="6">WCB/JCN number, OSHA accident number if applicable):</td></tr>
<tr><th colspan="6">MEDICAL PROVIDER (IF APPLICABLE)</th></tr>
<tr><td colspan="3">Did the employee receive medical care? ☐ YES ☐ NO</td><td colspan="3">If so, what date was medical care received?</td></tr>
<tr><td colspan="6">Medical Care Provider/Hospital:</td></tr>
<tr><td colspan="6">Address:</td></tr>
<tr><td colspan="2">City:</td><td colspan="2">State:</td><td colspan="2">Zip Code:</td></tr>
<tr><td colspan="3">Phone:</td><td colspan="3">Contact:</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="4">Signature of Employee Reporting Claim</td><td colspan="2">Date</td></tr>
<tr><th colspan="6">COMPLETED BY EMPLOYEE PREPARING THIS FORM</th></tr>
<tr><td colspan="4">Signature</td><td colspan="2">Date</td></tr>
<tr><td colspan="2">Print Name:</td><td colspan="2">Title:</td><td colspan="2">E-Mail:</td></tr>
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