NYS Workers' Compensation

EC-4NARR

DATE:_____

Patient Information:

Last Name:_____ First Name:_____ MI:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Date of Injury/onset:_____

On the date of injury/illness what was the patient's job title:_____

On the date of injury/illness what were the patient's usual work activities:

_____

What body part was affected by the injury/illness (what was the workers' compensation board decision):

_____

Is the patient working now? ____ Yes ____No

Employer Information

Name of employer when the injury occurred:_____

Employer Address:_____

City: _____State: _____Zip Code: _____

Employer Phone #:_____

Insurance Information

Insurance Carrier Name: _____

Insurance Carrier Address (Where medical claims should be sent):

_____

City:_____ State:_____ Zip Code: _____

Adjustor's Name: _____ Adjustor's Phone#:_____

WCB Case#: _____ Carrier Case #: _____

Attorney Name: _____ Tele:_____

*Please complete a separate form for each open workers compensation case.