New York Injured Worker Intake Form

* Indicates billing information required by the NYS Workers' Compensation Board

Injured Worker Demographics

Last Name:*	First Name:*	Middle Initial:
Date of Birth:*	SSN:	Gender:* ☐ F ☐ M
Address:*		
City:*	State:*	Zip:*
Telephone:		

Injury Claim Information

Claims Administrator Name:*	
Claim Number:*	Injury Start Date:*
WCB Case Number:	
Injury Description:	

Employer Information

Employer Name:*		
Address:*		
City:*	State:*	Zip:*

Additional Notes

Completed By: _____ Date: _____

daisyBill