

# NYSIF Report an Injury

Complete an Electronic First Report of Injury (eFROI) at [nysif.com](https://nysif.com)

[nysif.com/reportinjury](https://nysif.com/reportinjury)

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## Report an Injury

Employers **must** file a report of work-related injury or illness with NYSIF immediately upon becoming aware of the injury or illness, and no later than 10 days after the employer’s knowledge of the injury or illness, in all cases where the injury or illness:

- Has caused or will cause the employee’s loss of time from regular duties of one day beyond the workday or shift during which the incident occurred, or
- Has required or will require medical treatment beyond ordinary first aid, or more than two treatments by a person rendering first aid

**Once received, NYSIF will submit the report of injury to the Workers’ Compensation Board (WCB) on behalf of the employer.**

Visit [nysif.com/reportinjury](https://nysif.com/reportinjury) to start. To help you in completing your report, you may want to review our eFROI worksheet (at the end of this document), which details all the information requested in the report.

## Resume an eFROI

Do you have an eFROI Transaction ID and/or a Loss ID?

Enter the policy number and the Loss ID or eFROI Transaction ID.

Click **Start eFROI**.

**All fields are required unless otherwise stated.**

**Please complete as much eFROI information as possible and click "Save Form" before you exit your eFROI session.**

### Start or Resume Your eFROI

All fields are required unless otherwise stated.

Do you have an eFROI Transaction ID and/or a Loss ID?

Yes  No

Are you resuming an eFROI?

Yes  No

NYSIF Policy Number  
1234567

For example: enter A123-4567-8 as 12345678

eFROI Transaction ID  
NP20558391E211TCC

Transaction ID begins with NP or SP, followed by numbers and ends in letters

**Start eFROI**

## Start Your eFROI

If you do not have an eFROI Transaction ID or Loss ID, choose **No** to begin your report.

1. Enter your NYSIF policy number, date of injury/illness and employee information, including DOB and address.
2. Enter your information, as preparer of this report. (You must choose preparer type or you will not be able to proceed.)
3. Click **Start eFROI**.

### eFROI

Login

### Start or Resume Your eFROI

[Need Help?](#)

All fields are required unless otherwise stated.

Do you have an eFROI Transaction ID and/or a Loss ID?

Yes  No

**Start eFROI**

### Preparer Info

First Report of Injury Preparer Type

Employer  Third Party  NYSIF Employee

eFROI Initiator Email

This email address may be an individual or group email distribution

Broker/Safety Group Email (optional)

This email address will receive the same emails as the eFROI Initiator

OSHA Case Number (optional)

**Start eFROI**

### Start or Resume Your eFROI

All fields are required unless otherwise stated.

Do you have an eFROI Transaction ID and/or a Loss ID?

Yes  No

NYSIF Policy Number  
0000011

For example: A123-4567 as 1234567.

Date of Injury/Illness  
05/12/2021

Does the injured worker have a SSN?

Yes  No

First Name

Middle Initial (optional)

Last Name

Date of Birth  
mm/dd/yyyy

## eFROI Workflow

You can always view the status of your report using the icons across the top of the page. Green checkmarks indicate sections that are complete. Red circles indicate information is missing. A blue circle indicates the current page. You can choose a circle at any time to navigate to that section.



## Policyholder Information

The information displayed in the table is auto-completed based on the policy number you entered. (You cannot change this information.)

Choose the Policy Entity and Policy Location.

*TIP: Your entities will be listed in the drop-down in the order they are listed on your policy.*

### Transaction Detail

Please record this eFROI Transaction ID for future reference. [Need Help?](#)

eFROI Transaction ID NP20558391E21ITCC	Loss ID
---	---------

### Policyholder Information

All fields are required unless otherwise stated.  
Please complete as much eFROI information as possible and click "Save Form" before you exit your eFROI session.

<b>Name</b>	ACME BOX CO
<b>Address Line 1</b>	123 MAIN STREET
<b>Address Line 2</b>	
<b>City, State Zip</b>	ELMWOOD PARK, NJ 07407
<b>FEIN</b>	987654321
<b>Telephone Number</b>	555-555-5555

Policy Entity  
ACME BOX - 00000011

Policy Location  
123 MAIN STREET

<b>eFROI Initiator Email Address</b>	boss@nysif.com
<b>Broker/Safety Group Email Address</b>	

If your policy or policy entity does not have a NAIC code indicated in our system, you may be asked to identify the Industry Type for your business.

Policy Location Select a Location	
<b>eFROI Initiator Email Address</b>	
<b>Broker/Safety Group Email Address</b>	
Industry Type Select an Industry Type	
Select an Industry Type	
Accommodation and Food Services-72	
Administrative and Support and Waste Management and Remediation Services-56	
Agriculture, Forestry, Fishing and Hunting-11	
Arts, Entertainment, and Recreation-71	
Construction-23	
Educational Services-61	
Finance and Insurance-52	
Health Care and Social Assistance-62	
Information-51	
Management of Companies and Enterprises-55	
Manufacturing (Food, Beverage, Tobacco, Textiles, Apparel and Leather)-31	
Manufacturing(Metal, Machinery, Electronic, Appliance, Transport Equip., Furniture, Misc.)-33	
Manufacturing(Wood, Paper, Printing, Petroleum, Coal, Chemical, Plastics, Rubber, Nonmetal Mineral)-32	
Mining, Quarrying, and Oil and Gas Extraction-21	
Other Services (except Public Administration)-81	
Professional, Scientific, and Technical Services-54	
Public Administration-99	

Complete the question regarding the Claimant Information Packet.

Have you given the employee a Claimant Information Packet?

Yes  No

The Workers' Compensation Board requires employers to provide a Claimant Information Packet to workers at the time of their injury/illness. Select the Workers' Comp Claims Forms - Employer link on our [forms](#) page to download the latest version of the Claimant Information Packet for your employee.

Save Form Previous Next

Once this page is complete, click **Next**.

## Employee Information

The employee's name is carried over from the first page. If needed, you can amend the employee's mailing address here.

Employee's Personal Information

First Name  
Jane

Middle Initial (optional)

Last Name  
Doe

Date of Birth  
01/16/1970 

Enter work start time and time of injury, if available.

Indicate whether the employee gave notice of injury, and if so, to whom.

Once this page is complete, click **Next**.

### Employee's Injury Or Illness

Date of Injury/Illness  
05/12/2021

Employee began work at (optional)  
--:-- --  

(hh:mm AM/PM)

Time of Injury (optional)  
--:-- --  

(hh:mm AM/PM)

Has the employee given you notice of injury/illness?  
 Yes  No

If Yes, who was notice given to? (one of the following fields is required)

First Name

Last Name

If Yes, was notice given orally, in writing, or both?  
 Orally  In Writing  Both

Date Notice was Provided  
mm/dd/yyyy 

## Accident Information

Complete all fields regarding the accident/injury/illness, including the names of witnesses, if any.

If the accident location is not the same as the policy location, please indicate if the location was a "lessee" or "other."

Is the accident location the same as the policy location?

Yes  No

Accident Premises Code  
Select an Accident Premises Code

**-Lessee:** accident occurred on the premises of the lessee for which the injured was hired to work.  
**-Other:** accident occurred at a location other than the employer's or lessee's premises.

### Accident Information

All fields are required unless otherwise stated.

Where did the injury/illness happen? (e.g. 1 Main St, Accident City, NY. At front door)

This field accepts letters, numbers, space, enter, and ., ? # \$ ( ) - ; : ' " / &

Is the accident location the same as the policy location?

Yes  No

Accident County  
ALBANY

Was this the location where the employee normally worked?

Yes  No

Employee's Supervisor's First Name (optional)  
betsy

Employee's Supervisor's Last Name (optional)  
tester

Did the Supervisor see the injury happen?

Yes  No  Unknown

Describe what the injured worker was doing when they became injured or ill, along with how the injury/illness occurred.

Did anyone else see the injury happen?

Yes  No  Unknown

What was the employee doing when they were injured or became ill?

This field accepts letters, numbers, space, enter, and ., ? # \$ ( ) - ; : ' " / &  
200 characters left

How did the injury/illness occur?

This field accepts letters, numbers, space, enter, and ., ? # \$ ( ) - ; : ' " / &  
200 characters left

## Injury Cause

Select the body part and then the nature of injury from the drop-downs and then click **Add**. To add additional body parts, select another body part and nature of injury and click **Add** again. You are limited to 20 selections.

### Injury Cause

All fields are required unless otherwise stated.

Please complete as much eFROI information as possible and click "Save Form" before you exit your eFROI session.

**Select Body Part and Nature of Injury, then click "Add."**

To add additional body parts, select another Body Part and Nature of Injury and click "Add" again. Body parts are limited to twenty (20) selections.

Body Part

Select a Body Part ▾

Nature of Injury

Select Nature of Injury ▾

+ Add

**Select Body Part and Nature of Injury, then click "Add."**

To add additional body parts, select another Body Part and Nature of Injury and click "Add" again. Body parts are limited to twenty (20) selections.

<p>Body Part</p> <p>Arm, Lower Right ▾</p>	<p>Select Nature of Injury</p> <ul style="list-style-type: none"> <li>AIDS</li> <li>Amputation</li> <li>Angina Pectoris (Chest Pain)</li> <li>Asbestosis</li> <li>Asphyxiation (Strangulation, Drowning)</li> <li>Black Lung</li> <li>Burn (Heat and Chemical)</li> <li>Burn (Heat)</li> <li>Burn (Scald)</li> <li>Burn Chemical</li> <li>Byssinosis (Pneumoconiosis of cotton, flax and hemp workers.)</li> <li>COVID-19 - Coronavirus</li> <li>Cancer</li> <li>Carpal Tunnel Syndrome</li> </ul>
<p>Cause of Injury</p> <p>Select a Cause of Injury</p>	
<p>Type of Loss</p> <p>Select a Type of Loss</p>	

Arm, Lower Right	Contusion (Bruise)	<a href="#" style="color: red; text-decoration: none;">✕ Remove</a>
Elbow, Right	Crushing	<a href="#" style="color: red; text-decoration: none;">✕ Remove</a>
Cause of Injury		

Choose **Cause of Injury** from the drop-down. Example shown.

Arm, Lower Right	Contusion (Bruise)	<a href="#" style="color: red; text-decoration: none;">✕ Remove</a>
Elbow, Right	Crushing	<a href="#" style="color: red; text-decoration: none;">✕ Remove</a>
Cause of Injury	Crash of Motor Vehicle: Collision or sideswipe with another ▾	
<ul style="list-style-type: none"> <li>Caught in, under or between Collapsing Materials</li> <li>Caught in, under or between Machine or Machinery</li> <li>Caught in, under or between Object Handled</li> <li>Caught in, under or between, NOC</li> <li>Collision with a fixed object (standing vehicle or stationary object)</li> <li>Contact with Abnormal Air Pressure</li> <li>Contact with Chemicals (includes hydrochloric, sulfuric, battery acid; methanol, antifreeze)</li> <li>Contact with Cold Objects or Substances</li> <li>Contact with Dust, Gases, Fumes or Vapors</li> <li>Contact with Electrical Current</li> <li>Contact with Fire or Flame</li> <li>Contact with Hot Objects or Substances</li> <li>Contact with Radiation (includes xrays, microwaves, nuclear and sunburn)</li> <li>Contact with Steam or Hot Fluids</li> <li>Contact with Temperature Extremes</li> <li>Contact with Welding Operation. Includes welder's flash (burns to skin or eyes due to intense light from welding)</li> <li>Contact with, NOC</li> <li>Continual noise</li> <li>Crash of Airplane</li> <li style="background-color: #008080; color: white;">Crash of Motor Vehicle: Collision or sideswipe with another vehicle</li> </ul>		

Choose **Type of Loss:** Traumatic, Occupational Disease or Cumulative Disease

**Traumatic Injury:** Injury is traceable to an accident in the worker's present employment. Example: Slip or fall, struck by an object, injured while using equipment, suffered burns, etc.

**Occupational Disease:** Injury/illness caused by exposure to a disease producing agent in the worker's occupational environment. Not traceable to a definite accident in the worker's past or present employment. Example: An occupational disease arises from the conditions to which a specific type of worker is exposed. The disease must be produced as a natural incident of a particular occupation, such as asbestosis from asbestos removal.

**Cumulative Injury (other than disease):** Injury having occurred from, or aggravated by, a repetitive employment activity. Not traceable to a definite accident in the worker's past or present employment. Example: Carpal tunnel syndrome; hearing loss resulting from continued exposure to harmful noise over time, etc.

Answer a few additional questions. If the accident involved machinery or a motor vehicle, there will be additional details required from you. Click **Next**.

To your knowledge, did the employee have another work-related injury to the same body part or a similar illness while working for you?

Yes  No

Did the injury/illness result in the employee's death?

Yes  No  Unknown

Was an object involved in the injury/illness? (e.g. forklift, hammer, acid)

Yes  No

Was the injury the result of the use or operation of a licensed motor vehicle?

Yes  No

Did this injury occur in the course of patient handling?

Yes  No

## Medical Treatment

Please complete all fields regarding the injured employee's medical treatment (to the best of your knowledge).

Click **Next**.

### Medical Treatment

All fields are required unless otherwise stated.

Did the employee already receive treatment for this injury/illness?

Yes  No  Unknown

If yes, what was the date of the employee's first treatment?

mm/dd/yyyy

Extent of medical treatment received by claimant immediately following the accident(select one)

Minor on-site remedies by employer medical staff

Minor clinic/hospital medical remedies and diagnostic testing

Emergency evaluation, diagnostic testing, and medical procedures

Hospitalization greater than 24 hours

Future major medical/lost time anticipated(i.e.hernia case)

Who treated the employee?

Where was the employee treated?

Is the employee still being treated for this injury/illness?

Yes  No  Unknown

## Work Info

The last section before eFROI submission is information about the employee's work history: job title, occupation, class code, average gross weekly pay, work frequency, etc.

**Return To Work**  
Did the employee lose more than one day or one shift because of their injury/illness?

Yes  No

If yes, what was the last date the employee worked?  
mm/dd/yyyy

What was the first scheduled work day or work shift they missed after the accident?  
mm/dd/yyyy

When did the employer become aware that the employee's lost time was due to their injury/illness?  
mm/dd/yyyy

Has the employee returned to work?

Yes  No

If yes, on what date?  
mm/dd/yyyy

If yes, in what capacity?

Regular Duty  Limited Duty

If yes, did employee return to work with physical restrictions?

Yes  No

If yes, did employee return to work with the same employer?

Yes  No

Employee's job is

Regular/Full-Time

Part-Time Employee

Volunteer

Seasonal

Piece Worker

Apprenticeship Full-Time

Apprenticeship Part-Time

Unemployed/Not Employed

Retired

On Strike

Disabled

Other

## eFROI Submission

Before submitting, be sure to make a note of your eFROI Transaction ID.

Enter your contact information, click the attestation box and click **Submit eFROI**.

I affirm that the information I am providing is true and accurate to the best of my knowledge and belief.

Are you, the "submitter" the same person as the "notifier" for this FROI-00 transaction?

Yes  No

Name & Telephone Number of Employer/Policyholder who provided information necessary to prepare this form:

First Name

Last Name

Telephone Number

Extension (optional)

Numbers only - include area code

Up to 5 digits

**A confirmation page will display. Be sure to make a note of the Loss ID and the Transaction ID.** (A Transaction ID begins with NP or SP, followed by several numbers and letters.)

### Thank you for using eFROI!

Your FROI-00 has been successfully created and will be sent to the Workers' Compensation Board (WCB). Your loss record identification number a/k/a claim number is shown below. Please refer to this loss record identification number when communicating with NYSIF.

Loss Record Identification Number  
0321654

eFROI Transaction ID  
SP20558391E211XYZ

To [view and/or print a copy of the FROI-00](#), please enter:

- Your policy number
- The last four digits of the injured worker's SSN, or if not available, the eFROI Transaction ID (as shown above)
- The loss record identification number (as shown above)

NYSIF may contact you to confirm the information contained in this report so that this claim may be processed in a timely manner. Please be available to provide any additional information that may be required.

On and after April 1, 2009, you must also provide your injured employee with a Claimant Information Packet before filing the Employer's Report of Work-Related Injury/Illness (Form FROI-00). The Claimant Information Packet is available in several languages under the "Workers' Comp Claim Forms - Employer" section and can be accessed by clicking on the link below.

## For New York State Agencies & Employees

To report a New York State agency employee injury, call the state Accident Reporting System at 1-888-800-0029.

For those state entities that report via eFROI, you will be asked to choose the bargaining unit, policy entity and include the employee's NYS Employee ID number.

NYSIF Policy Number 240960
For example: A123-4567 as 1234567.
Is injured worker a volunteer? <input type="radio"/> Yes <input checked="" type="radio"/> No
Bargaining Unit Select a Bargaining Unit
Policy Entity Select an entity
Date of Injury/Illness mm/dd/yyyy
Does the injured worker have a SSN? <input type="radio"/> Yes <input type="radio"/> No
Does Injured Worker have a NYS Employee ID or 'N-number'? <input type="radio"/> Yes <input type="radio"/> No

## NYSIF eFROI Worksheet

<b>Initial Information: (If resuming an eFROI, you must have the Transaction ID)</b>	
* NYSIF Policy Number (must be active on Date of Accident being reported)	
* Date of Injury/Illness	
* Does Injured Worker have a SSN? If yes, SSN is required.	
* First and Last Name of Injured Worker	
* Date of Birth of Injured Worker	
* Mailing Address of Injured Worker	
* First Report of Injury Preparer (Employer, Third Party or NYSIF Employee)	
* eFROI Initiator e-mail address	
Broker/Safety Group Manager's email (optional)	
<b>Policyholder Information:</b>	
* Policy Entity	
* Policy Location	
* Industry Type	
* Did you give the employee a Claimant Information Packet? If yes, date required.	
<b>Employee Information:</b>	
* Gender	
Telephone Number	
Employee's Mailing Address (update if necessary)	
Time employee began work	
Time of injury	
* Did employee give notice of accident/illness? If yes, must indicate when and to whom. Was it given orally, in writing or both?	
<b>Accident Information:</b>	
* Where did the accident/illness happen?	
* Is the accident location the same as the policy location? If no, select Accident Premises Code (Lessee or Other)	
* Accident County	
* Was this the location where the employee normally worked? If no, indicate why the employee was there.	
First and Last Name of Employee's Supervisor	
* Did Supervisor see injury happen?	
* Did anyone else see injury happen? If yes, need names and contact info.	
* What was employee doing when they were injured or became ill?	
* How did the injury/illness occur?	
<b>Injury Information:</b>	
* Body part(s) injured (up to 20 body parts may be selected)	
* Nature of Injury (such as laceration, bruise, fracture, burn, etc.)	
* Cause of Injury (ex: caught under vehicle, contact with fire, tripped over wire)	
* Type of Loss (traumatic, occupational disease or cumulative injury)	

\* required fields

* To your knowledge, did the employee have another work-related injury to the same body part or similar illness while working for you?	
* Did the injury/illness result in the employee's death?	
* Was an object involved in the injury/illness? If yes, what object?	
* Was the injury the result of the use or operation of a motor vehicle? If yes, was it the employee's vehicle, employer's vehicle or other vehicle?	
* Did this injury occur in the course of patient handling?	
<b>Medical Treatment Information:</b>	
* Did the employee receive treatment for this injury/illness? If no, skip this section.	
* What was the date of the employee's first treatment?	
* What was the extent of medical treatment received by claimant immediately following the accident? (minor, emergency room, hospitalization, etc.)	
* Who treated the employee?	
* Where was the employee treated?	
* Is the employee still being treated?	
<b>Employment Information:</b>	
* Did the employee lose more than one day or one shift because of their injury/illness?	
* What was employee's last date worked?	
* What was the first scheduled work day or work shift they missed after the accident?	
* When did the employer become aware that the employee's lost time was due to their injury/illness?	
* Has employee returned to work? If yes, on what date?	
* If employee returned to work, was it regular duty or limited duty?	
* If employee returned to work, was it with physical restrictions?	
* If employee returned to work, was it for the same employer?	
Date of Hire	
Job Title	
* Occupation Description	
* Manual Classification Code	
What types of activities did claimant normally perform at work?	
* Employee's average gross weekly pay	
* Did employee receive lodging or tips in addition to pay? If yes, describe.	
* Employee's job was... (choose Full-Time, Part-Time, Seasonal, etc.)	
* Which days of the week did the employee usually work?	
Last Day Paid	
* Was the employee paid for a full day on the day of the injury/illness?	
* Did you continue to pay the employee after the injury/illness?	
<b>Additional Information:</b>	
Please provide any additional information. (This information is provided to NYSIF only)	
* FROI submitter contact information	

\* required fields