NYSIF Report an Injury

Complete an Electronic First Report of Injury (eFROI) at nysif.com

nysif.com/reportinjury

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** 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

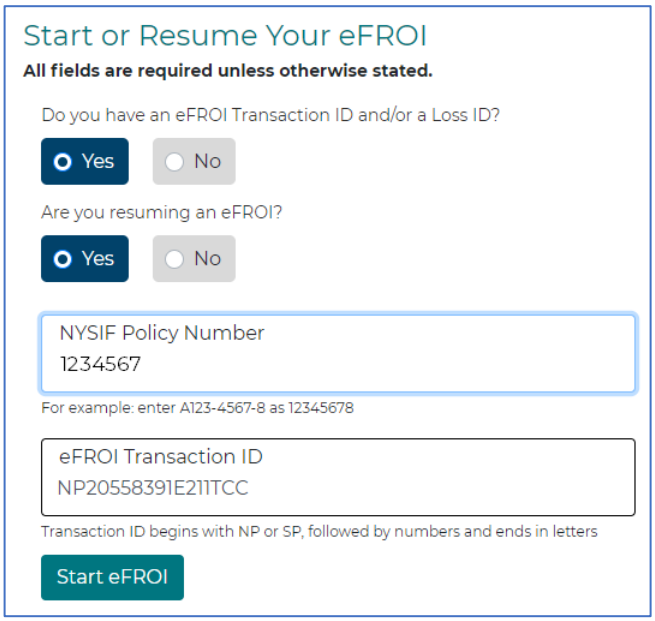
Do you have an eFROI Transaction ID and/or a Loss ID?

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

Click **Start eFROI.**

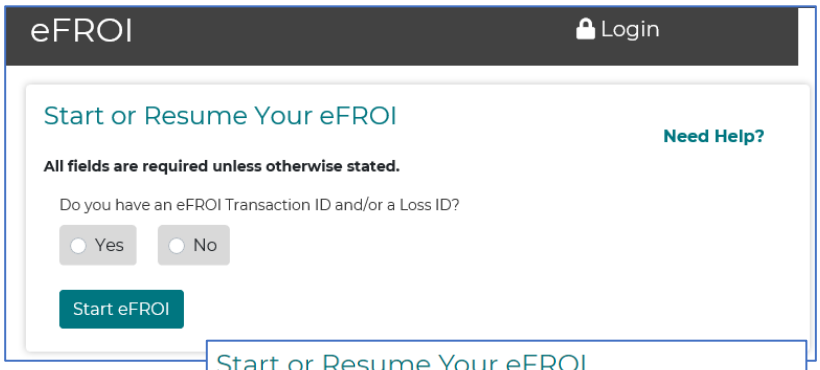
All fields are required unless otherwise stated.

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

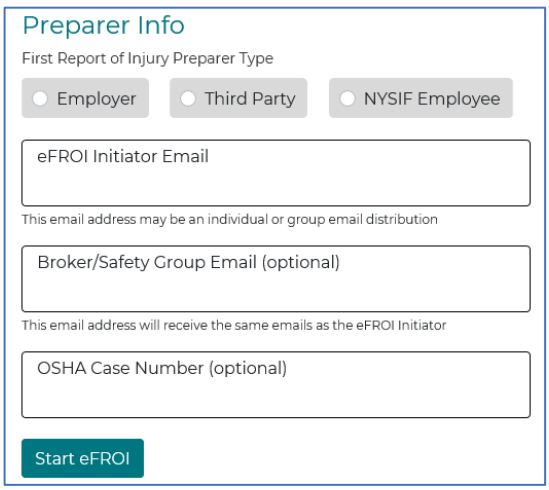


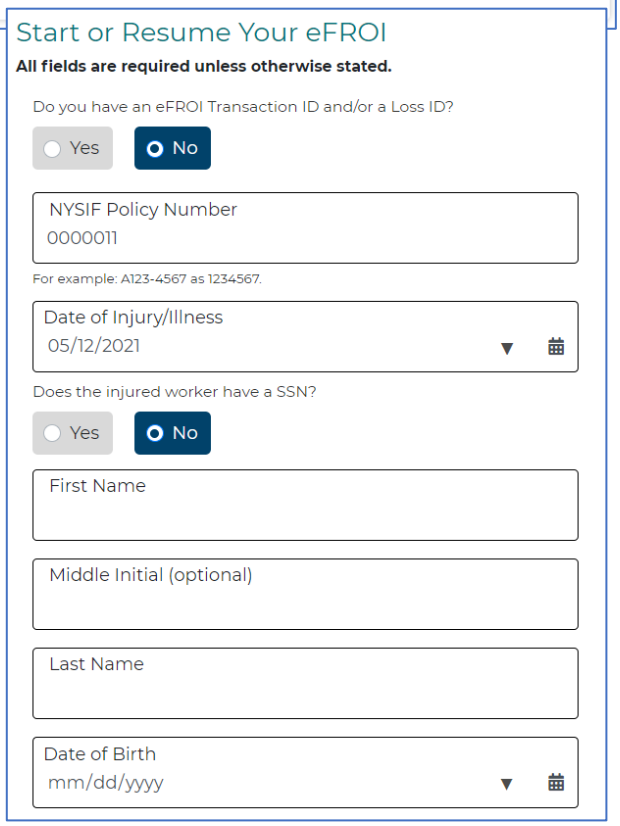
Start Your eFROI

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 Workflow

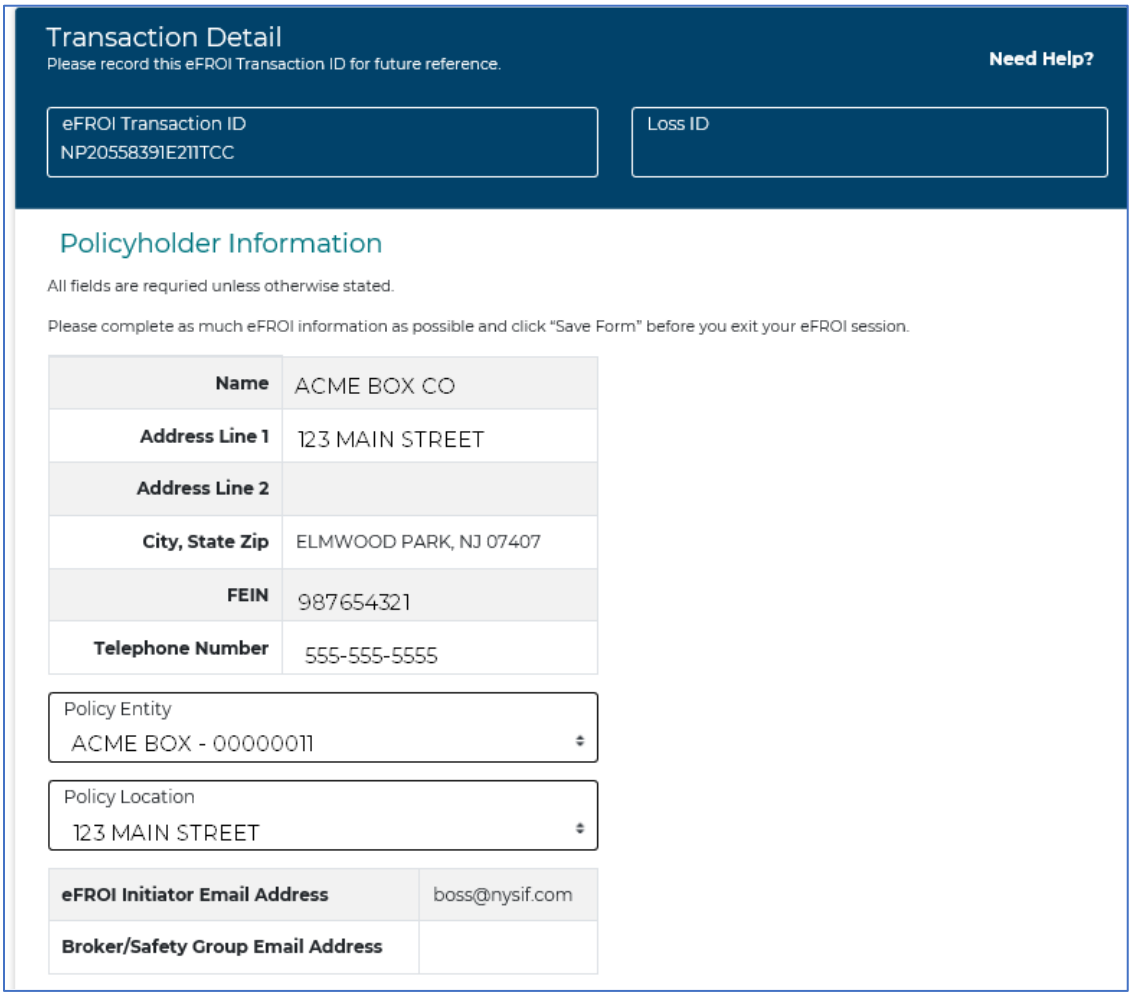
You can always view the status of your report using the icons across the top of the page. Green checkmarks indicate sections that are complete. Red circles indicate information is missing. A blue circle indicates the current page. You can choose a circle at any time to navigate to that section.

Policyholder Information

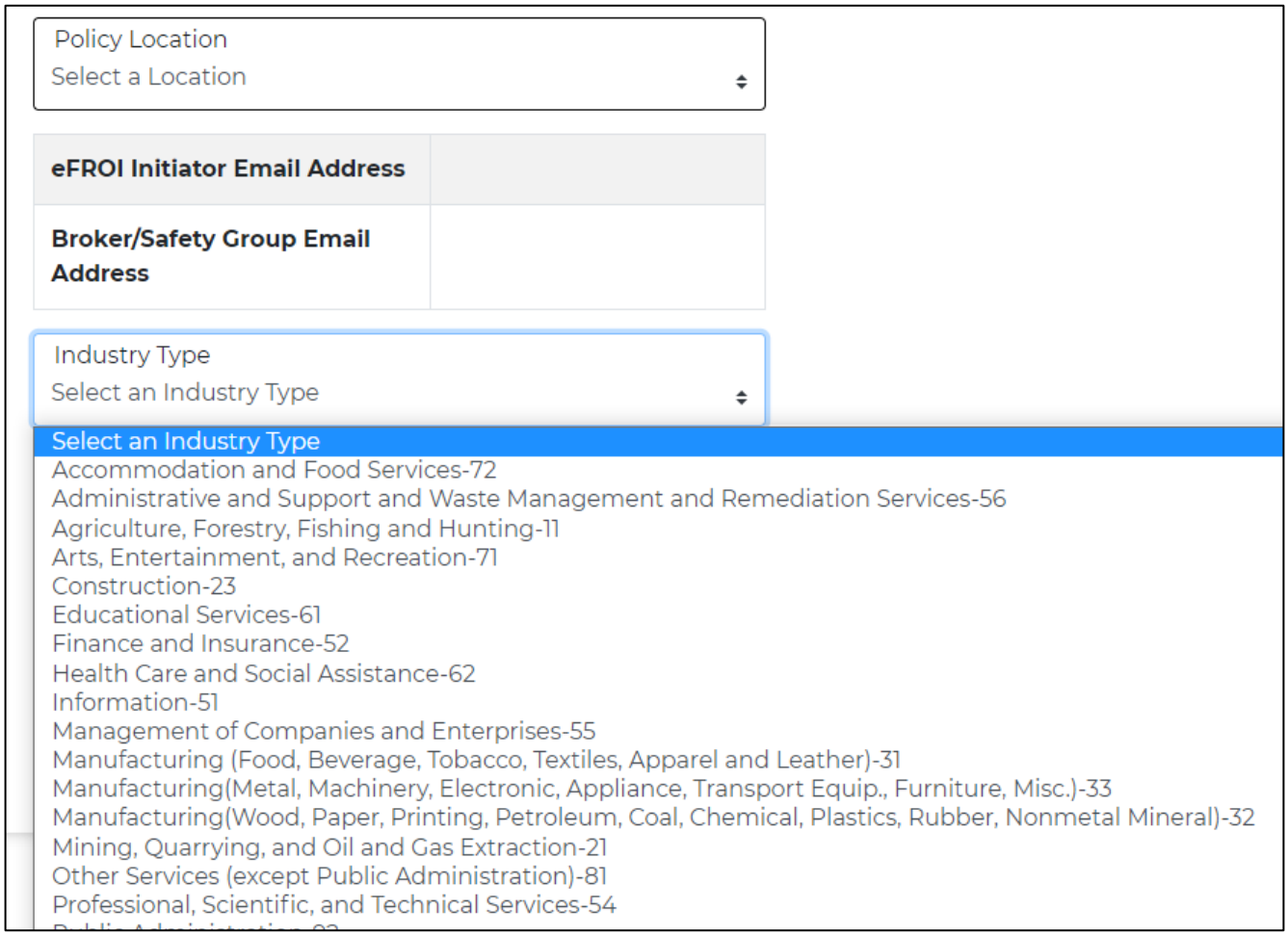
The information displayed in the table is auto-completed based on the policy number you entered. (You cannot change this information.)

Choose the Policy Entity and Policy Location.

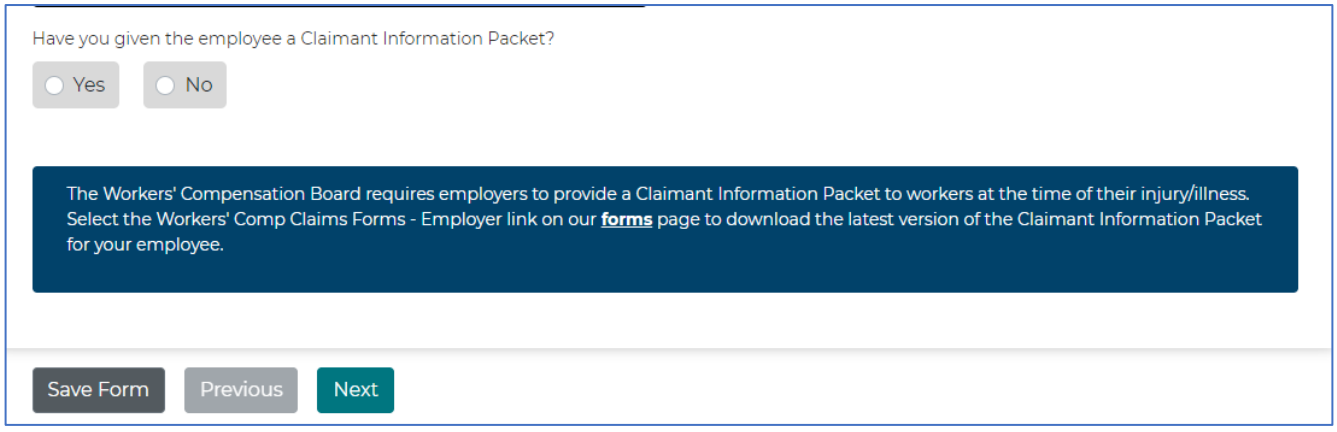
TIP: *Your entities will be listed in the drop-down in the order they are listed on your policy.*



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.



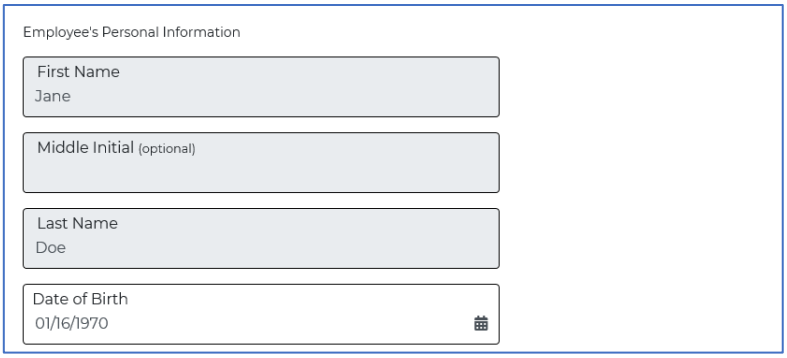
Complete the question regarding the Claimant Information Packet.



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

Employee Information

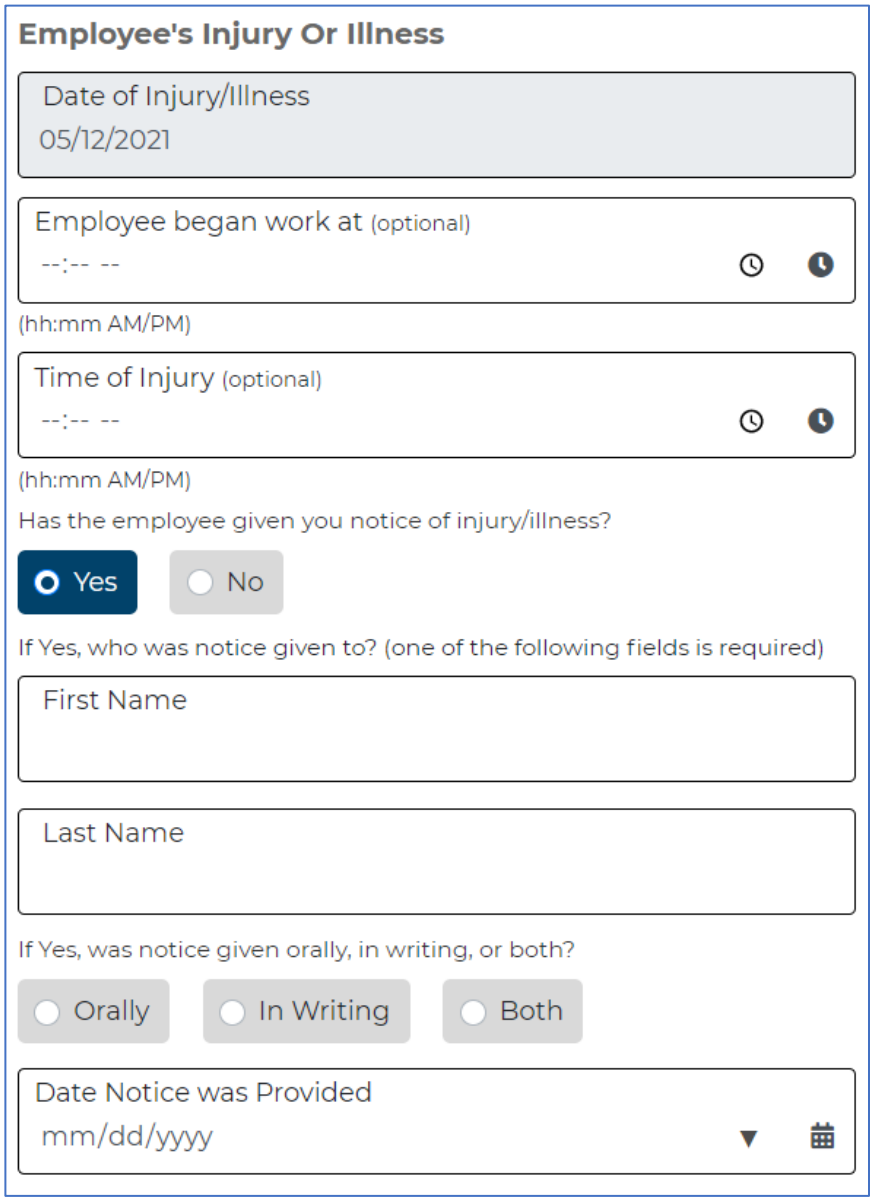
The employee's name is carried over from the first page. If needed, you can amend the employee's mailing address here.



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

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

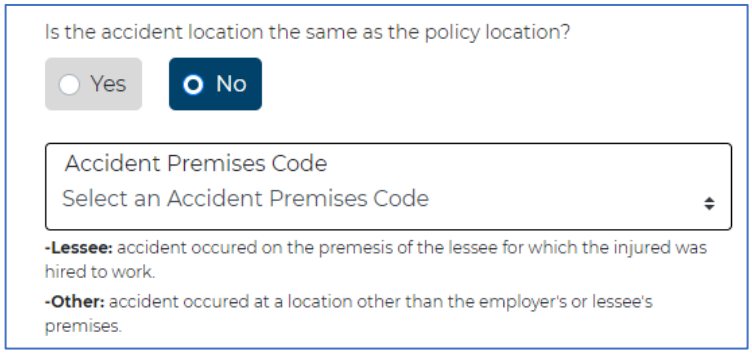
Once this page is complete, click **Next.**

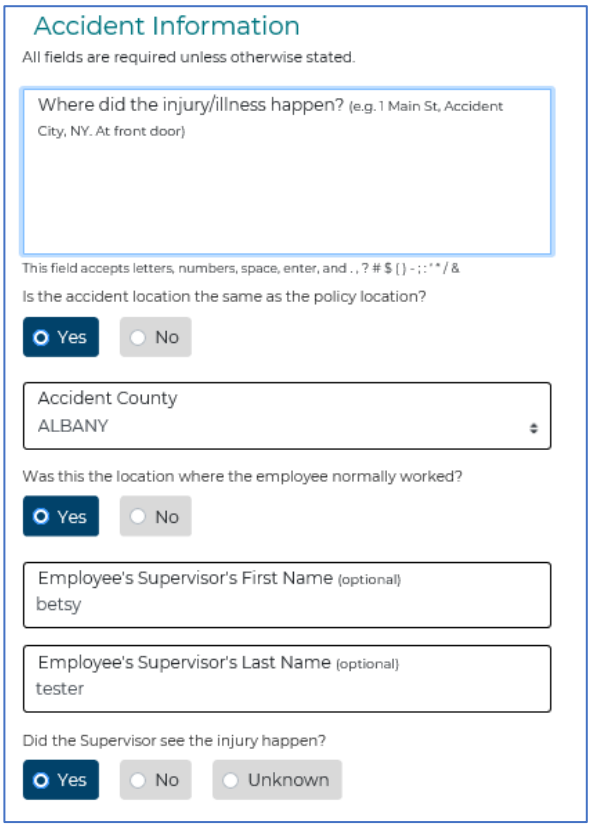


Accident Information

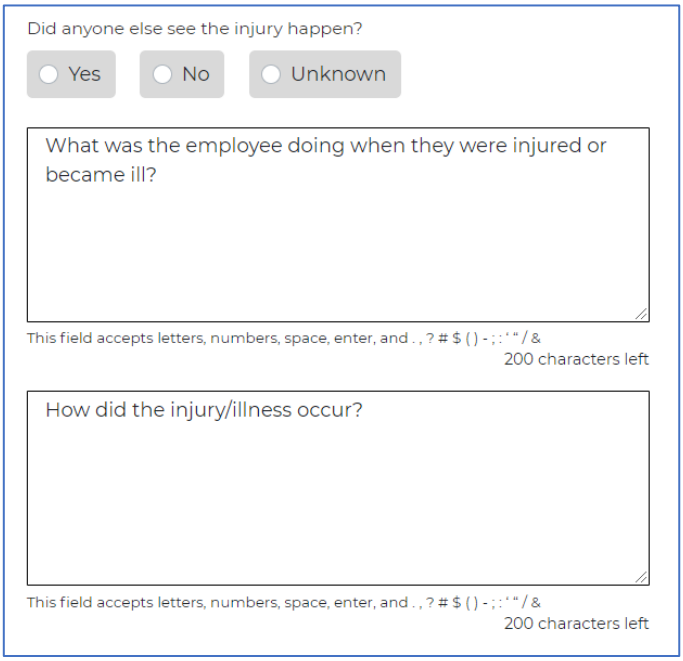
Complete all fields regarding the accident/injury/illness, including the names of witnesses, if any.

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



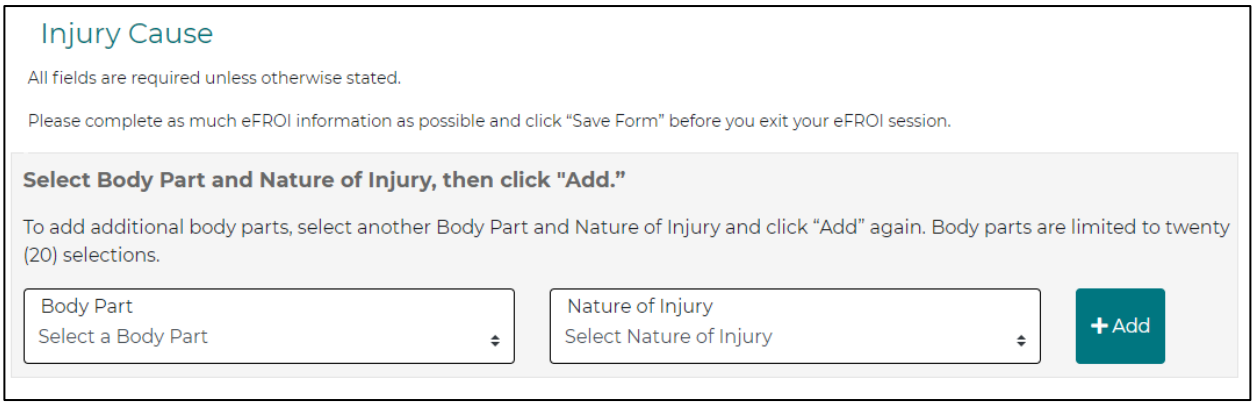


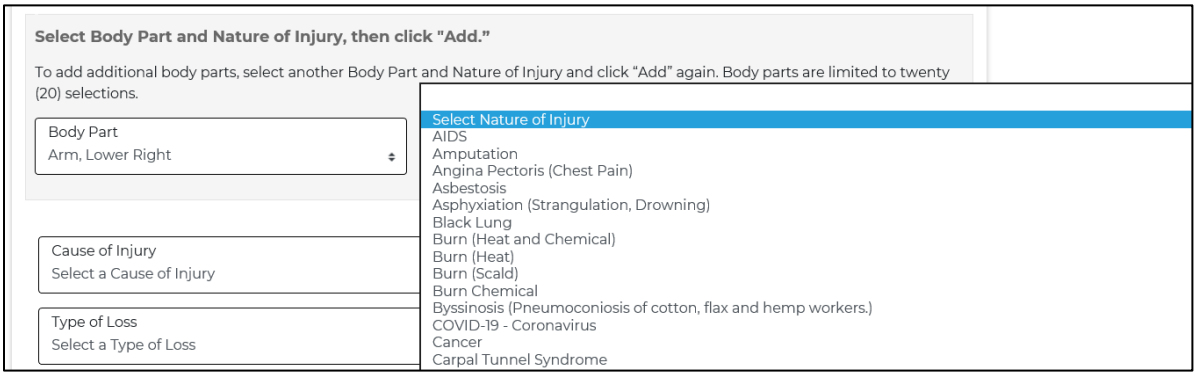
Describe what the injured worker was doing when they became injured or ill, along with how the injury/illness occurred.

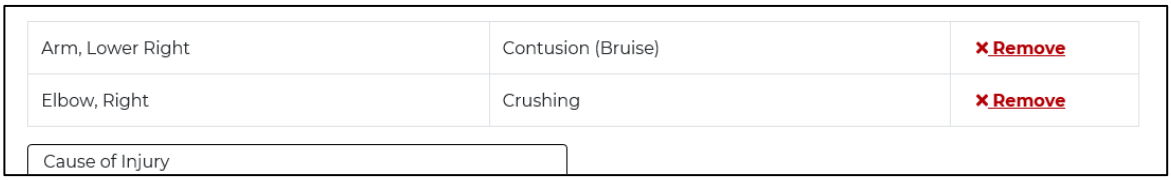


Injury Cause

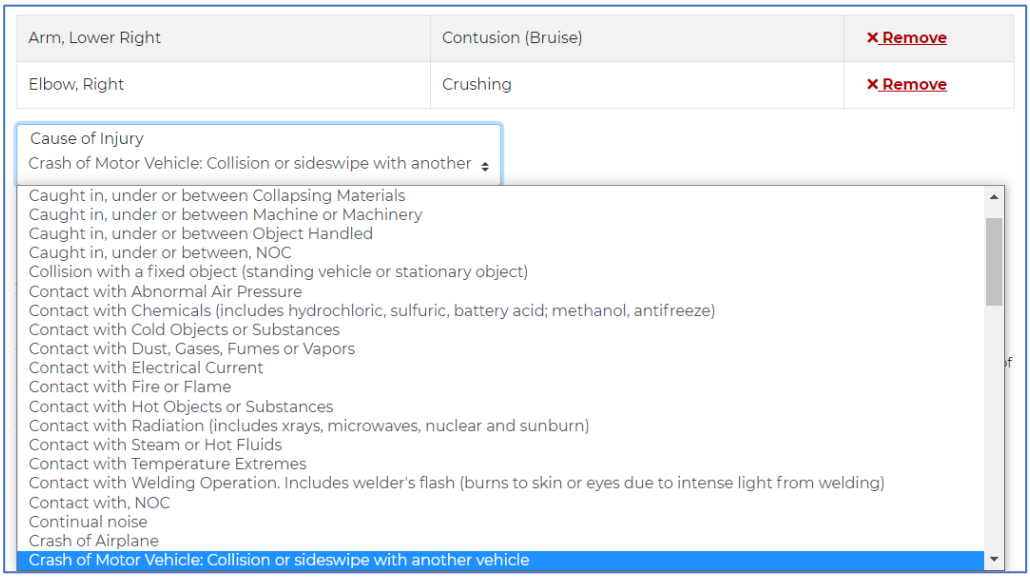
Select the body part and then the nature of injury from the drop-downs and then click **Add.** To add additional body parts, select another body part and nature of injury and click **Add** again. You are limited to 20 selections.







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

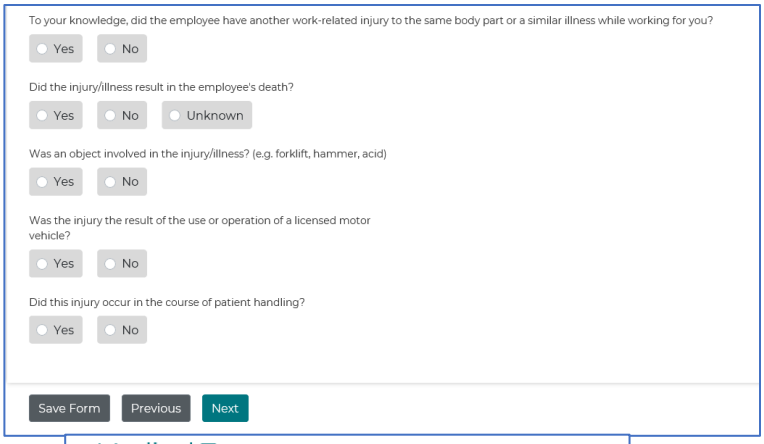


Choose **Type of Loss:** Traumatic, Occupational Disease or Cumulative Disease

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.

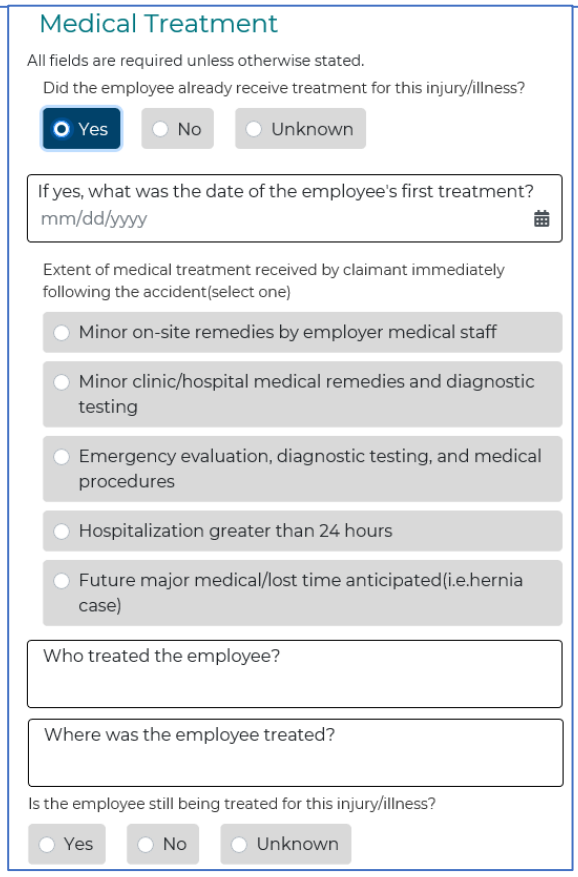


Answer a few additional questions. If the accident involved machinery or a motor vehicle, there will be additional details required from you. Click **Next.**

Medical Treatment

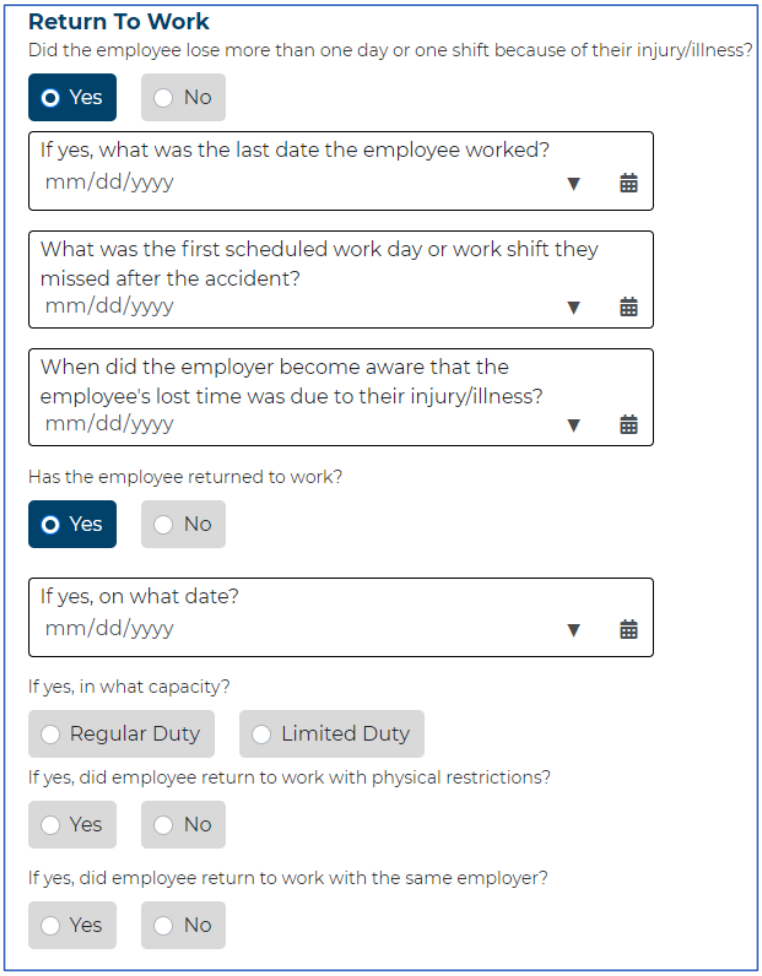
Please complete all fields regarding the injured employee's medical treatment (to the best of your knowledge).

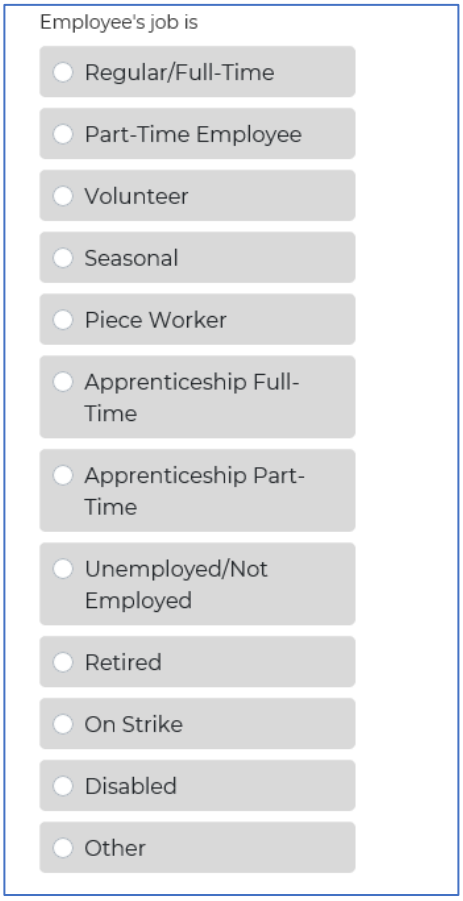
Click **Next.**



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.

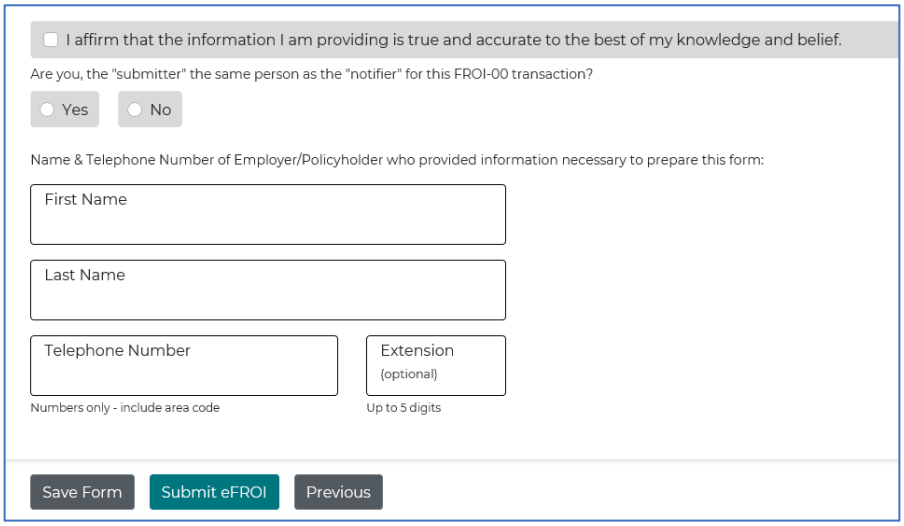




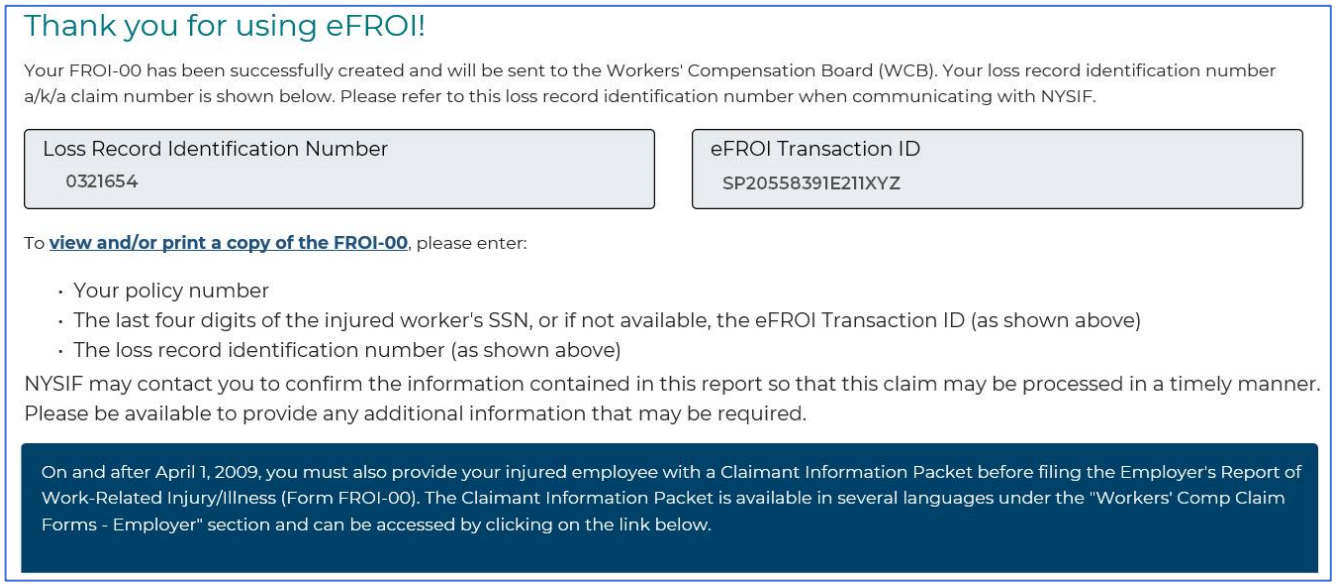
eFROI Submission

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.**



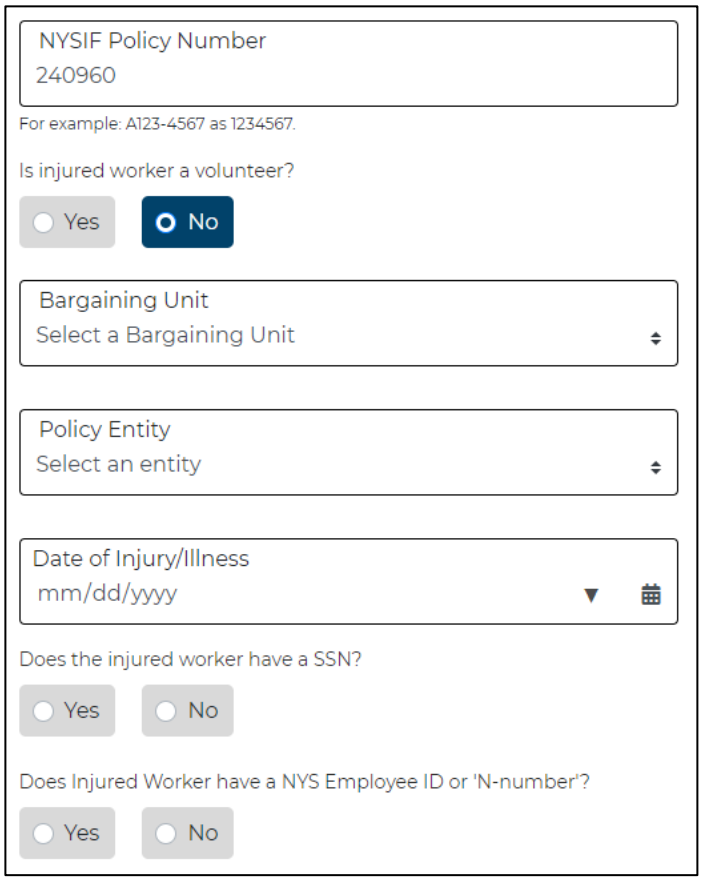
A confirmation page will display. Be sure to make a note of the Loss ID and the Transaction ID. (A Transaction ID begins with NP or SP, followed by several numbers and letters.)



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 eFROI Worksheet

Initial Information: (If resuming an eFROI, you must have the Transaction ID)	
* 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)	
Policyholder Information:	
* Policy Entity	
* Policy Location	
* Industry Type	
* Did you give the employee a Claimant Information Packet? If yes, date required.	
Employee Information:	
* 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?	
Accident Information:	
* 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?	
Injury Information:	
* 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?	
Medical Treatment Information:	
* 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?	
Employment Information:	
* 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?	
Additional Information:	
Please provide any additional information. (This information is provided to NYSIF only)	
* FROI submitter contact information	

* required fields