JEFFREY SIDER MD

MIDISLAND ORTHOPEDICS AND SPORTS MEDICINE

812 Woodbury Rd.
Woodbury, New York 11797
TEL-516- 935-1234

The following is an agreement to pay medical costs in the event your compensation claim is disallowed:

ALL INFORMATION MUST BE PROVIDED – THANK YOU

Claimant: ____________________
Date of Injury: ____________________
WCB Case No: ____________________

In the event I fail to prosecute the claim for workers compensation for this illness or condition, or it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable case. I hereby agree to pay Jeffrey S. Sider, M.D. located at 812 Woodbury Rd., his usual and customary fees for services rendered to the above named claimant in the above identified case either by my private insurance or directly by myself.

Date: ____________________ Signature: ____________________

If signed by other than claimant please provide name, address and relationship:

____

***** Provide a brief history of accident or cause of condition:**

____
____
____
____

Are you working presently: ________________ **If no, last day worked:** ____________

Have you been treated by any hospital or doctor for this injury/condition: ____________

If yes, provide details with name, address and treatment rendered:

____
____
____

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
EMPLOYEE'S CLAIM FOR COMPENSATION

ANSWER ALL QUESTIONS FULLY - TYPE OR PRINT CLEARLY

IMPORTANT: Your Social Security Number Must Be Entered: ☐☐☐ ☐☐ ☐☐☐☐
IMPORTANTE: El Numero de su Seguro Social Debe Ser Indicado:

WCB Case No. (If known)______________ Carrier Case No.(if known)______________

Section	Questions
A. Injured Person	1. Name........ First Name ... Middle Name ... Last Name 2. Mailing Address........ Number and Street (include Apartment No.) City ... State ... Zip Code 3. Residential Address (if different from mailing address) .... 4. Sex ☐ Male ☐ Female Date of Birth........Telephone No. ( )........ 5. Do you speak English? ☐ Yes ☐ No If no, what language do you speak?........ 6. Name of union and local number, if member........ 7. State what your regular work/occupation was........ 8. Wages or average earnings per day, including overtime, board, rent and other allowances........ 9. Were you paid full wages for the day of injury? ☐ Yes ☐ No 10. Your work week at time of injury was: ☐ Five day ☐ Six day ☐ Seven day ☐ Other........
B. Employer(s)	1. Employer........Telephone No. ( )........ 2. Employer's Address........ 3. Were you employed by any other employer or employers at the time of your injury/illness? ☐ Yes ☐ No 4. If yes, did you lose time from work at this other employment as a result of your injury/illness? ☐ Yes ☐ No
C. Place/Time	1. Address where injury occurred........County........ 2. Date of Injury........at........o'clock, ☐ AM ☐ PM
D. The Injury	1. How did injury/illness occur?........ .... 2. Did anyone witness the injury? ☐ Yes ☐ No If yes, name(s)........ 3. Is the injury the result of the use or operation of a motor vehicle? ☐ Yes ☐ No If Yes, ☐ your vehicle ☐ employer's vehicle If your vehicle was involved, give name & address of your motor vehicle (No-Fault) insurance carrier........ ....
E. Nature and Extent of Injury/ Illness	1. State fully the nature of your injury/illness, including all parts of body injured........ .... 2. Date you stopped work because of this injury/illness?........ 3. Have you returned to work? ☐ Yes ☐ No If yes, on what date?........ 4. Does injury/illness keep you from work? ☐ Yes ☐ No 5. Have you done any work during period of disability? ☐ Yes ☐ No 6. Have you received any wages since your injury/illness? ☐ Yes ☐ No
F. Medical Benefits	1. Did you receive or are you now receiving medical care? ☐ Yes ☐ No 2. Are you now in need of medical care? ☐ Yes ☐ No 3. Name of attending doctor........ Doctor's address........ 4. If you were in a hospital, give the dates hospitalized........ Name of hospital........ Hospital's Address........
G. Comp. Payments	1. Have you received or are you now receiving workers' compensation payments for the injury reported above? ☐ Yes ☐ No 2. Do you claim further workers' compensation payments? ☐ Yes ☐ No
H. Notice	1. Have you given your employer (or supervisor) notice of injury? ☐ Yes ☐ No 2. If yes, notice was given ☐ orally ☐ in writing, on........ to........

I hereby present my claim to the Chair, Workers' Compensation Board, for compensation for disability resulting from an accidental injury or occupational disease arising out of and in the course of my employment and not occasioned by my willful intention or solely through intoxication, and in support of it I make the foregoing statement of facts.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO, OR BY AN INSURER, OR SELF INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Signed by........................ Dated........................
(Claimant)

SEE OTHER SIDE FOR IMPORTANT INFORMATION - VEASE AL DORSO PARA INFORMACION DE IMPORTANCIA

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.
LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS INCAPACITADAS SIN DISCRIMINAR.