

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

THIS AGENCY EMPLOYS AND SERVES
PEOPLE WITH DISABILITIES WITHOUT
DISCRIMINATION.

**NOTICE TO LIABLE POLITICAL SUBDIVISION OR UNAFFILIATED AMBULANCE
SERVICE OF VOLUNTEER AMBULANCE WORKER'S INJURY OR DEATH**

THIS NOTICE IS REQUIRED TO BE FILED WITHIN 90 DAYS AFTER THE DATE OF INJURY OR DEATH UNLESS CLAIM FOR BENEFITS, INCLUDING MEDICAL, HOSPITAL OR OTHER CARE, (VAW-3 or VAW-62) IS FILED WITHIN 90 DAYS AFTER THE DATE OF INJURY OR DEATH.

Sec. 40 of the Volunteer Ambulance Workers' Benefit Law provides that, unless claim for benefits is filed within 90 days after injury or death, notice of such injury or death shall be given by delivery in person or by registered mail within 90 days by the injured volunteer ambulance worker or by any person claiming to be entitled to benefits, or by someone in his/her behalf, to the designated officer of the liable political subdivision as follows:

If the political subdivision liable for benefits is a

- a. County
- b. City
- c. Town
- d. Village
- e. Ambulance District

Then give to

- a. Clerk of the Board of Supervisors
- b. Comptroller or Chief Financial Officer
- c. Town Clerk
- d. Village Clerk
- e. Secretary

If at the time of injury the volunteer ambulance worker was a member of a voluntary service which was not affiliated with a county, city, town, village or ambulance district, this notice is to be filed with the ambulance service in which he or she served. However, please note that such unaffiliated services are not required to have coverage under the Volunteer Ambulance Workers' Benefit Law.

THIS NOTICE IS NOT A CLAIM FOR BENEFITS. FAILURE TO FILE THE CLAIM FOR BENEFITS (FORM VAW-3 or VAW-62) WITHIN TWO YEARS AFTER INJURY OR DEATH MAY BAR YOU FROM RECEIVING BENEFITS.

To: _____
Name of Officer
Title of Officer
Political Subdivision Liable for Benefits

1. VOLUNTEER AMBULANCE WORKER	First Name	Middle Initial	Last Name	Home Address	Apt. No.
2. AMBULANCE COMPANY	Name			Address	
3. POLITICAL SUBDIVISION OR AMBULANCE DISTRICT, IF ANY					
4. REGULAR EMPLOYER, IF ANY					

5. Address where injury occurred _____

6. (a) Date of injury _____ at _____ o'clock _____ M. (b) Date of death _____

(c) Place of death _____

7. State fully nature and cause of injury or death _____

Dated _____

Signed by _____,

Volunteer Ambulance Worker

Signed by _____

A person on his/her behalf, or in case of death, by any one or more of his/her dependents, or by a person on their behalf.

Relationship

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

POLITICAL SUBDIVISION'S REPORT OF INJURY TO VOLUNTEER AMBULANCE WORKER

Send this Report directly to Chair, Workers' Compensation Board at address shown on reverse side within ten (10) days after injury is incurred. Answer all questions fully. Copy also should be provided to or retained by your insurance carrier.

Any political subdivision that fails to timely file Form VAW-2, as required by Section 110 of the Workers' Compensation Law and Section 42 of the Volunteer Ambulance Workers' Benefit Law, shall be subject to a fine of not more than \$1,000. In addition, the Board or Chair may impose a penalty of up to \$2,500.

TYPEWRITER PREPARATION IS STRONGLY RECOMMENDED - INCLUDE ZIP CODE IN ALL ADDRESSES-VOLUNTEER AMBULANCE WORKER'S S.S.NO. MUST BE ENTERED

WCB CASE NO.(If Known)	CARRIER CASE NO.	CARRIER CODE NO.	VAW POLICY NO.	SOCIAL SECURITY NO.
		W-802003		
NAME		ADDRESS		
1. POLITICAL SUBDIVISION OR AMBULANCE DISTRICT				
2. AMBULANCE COMPANY				
3. INSURANCE CARRIER IF ANY	Allegany County Mutual Self-Insurance Plan	7 Court Street, Room 218, Belmont, NY 14813		
I P N E J R U S R O N E D	4. NAME AND ADDRESS OF VOLUNTEER AMBULANCE WORKER		5.(a) SEX	5.(b) DATE OF BIRTH month day year
	6. NAME AND ADDRESS OF REGULAR EMPLOYER		7. HAS INJURED AMBULANCE WORKER RETURNED TO REGULAR EMPLOYMENT <input type="checkbox"/> Yes <input type="checkbox"/> No	
I N J U R Y	8. WHERE DID INJURY OCCUR? (Specify in building, outside building, en route in ambulance, etc.)			
	9. CHECK ONE: <input type="checkbox"/> THE ABOVE-NAMED VOLUNTEER AMBULANCE WORKER WAS INJURED IN THE LINE OF DUTY WHILE SERVING WITH HIS/HER OWN AMBULANCE COMPANY OR AMBULANCE DEPARTMENT. <input type="checkbox"/> THE ABOVE-NAMED VOLUNTEER, MEMBER OF ANOTHER AMBULANCE DEPARTMENT, WAS INJURED IN LINE OF DUTY AFTER HIS/HER SERVICES HAD BEEN ACCEPTED BY THE ABOVE-NAMED AMBULANCE COMPANY OR DEPARTMENT.			
	10. DATE OF INJURY	11. DATE DISABILITY BEGAN	12. DATE OF FIRST KNOWLEDGE OF INJURY	13. WAS NOTICE OF INJURY GIVEN IN WRITING <input type="checkbox"/> Yes <input type="checkbox"/> No
	14. ADDRESS WHERE INJURY OCCURRED		15. NAMES AND ADDRESSES OF WITNESSES (Attach separate sheet if necessary.)	
	16. NATURE OF INJURY AND PART(S) OF BODY AFFECTED: (e.g., "INJURY TO CHEST", etc.)			17. DID YOU PROVIDE MEDICAL CARE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, WHEN
	18. (a) NAME AND ADDRESS OF DOCTOR		(b) NAME AND ADDRESS OF HOSPITAL	
C A U S E O F I N J U R Y	19. WHAT WAS AMBULANCE WORKER DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material ambulance worker was using.)			
	20. HOW DID THE INJURY OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)			
	21. (a) WAS PROTECTIVE EQUIPMENT PROVIDED. (Such as gas mask, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) WAS PROTECTIVE EQUIPMENT IN USE AT THE TIME? <input type="checkbox"/> Yes <input type="checkbox"/> No (c) WAS PROTECTIVE EQUIPMENT DEFECTIVE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, IN WHAT WAY (Attach separate sheet if necessary.)			
FATAL CASES	22. (a) DATE OF DEATH	(b) NAME AND ADDRESS OF NEAREST RELATIVE		(c) RELATIONSHIP
P R E P A R A T I O N	DATE OF THIS REPORT		IF FORM IS SUBMITTED BY POLITICAL SUBDIVISION, COMPLETE A & B BELOW. IF FORM IS SUBMITTED BY THIRD PARTY, COMPLETE A,B,C & D BELOW.	
	A. PERSON PREPARING FORM OR SUPPLYING INFORMATION TO THIRD PARTY		B. TITLE	TELEPHONE NUMBER & EXTENSION
	C. IF REPORT PREPARED BY THIRD PARTY, COMPANY NAME AND ADDRESS			
	D. THIRD PARTY CONTACT NAME		TELEPHONE NUMBER & EXTENSION	

VAW-2 (1-11)

VAW-2

VAW-2

VAW-2

VAW-2

TO BE COMPLETED BY CHIEF OFFICER OR DESIGNATED SUPERIOR



VOLUNTEER AMBULANCE WORKER'S CLAIM FOR BENEFITS

SEE REVERSE FOR FILING INSTRUCTIONS

Does this claim involve disease or malfunction of the heart or of one or more coronary arteries? (Check one) Yes No

W.C.B. CASE NO. (if known) CARRIER CASE NO. (if known) CARRIER CODE NO. DATE OF INJURY SOCIAL SECURITY NO.

First Name Middle Initial Last Name Address (Give Number and Street, City, State, Zip Code) Apt. No.

1. VOLUNTEER AMBULANCE WORKER
2. AMBULANCE COMPANY
3. POLITICAL SUBDIVISION

INFORMATION, REGULAR WORK
4. (a) Marital Status (b) Sex (c) Date of Birth (e) Tel. No.
5. Describe in detail your duties in regular employment
6. Your work week at time of injury was (check one) 5 days 6 days 7 days Other
7. Employer's name and address

INJURY
8. (a) Were you injured in the line of duty in the jurisdiction of your own ambulance district or political subdivision? Yes No
(b) If you were injured in the line of duty involving assistance call from another locality, give name of other ambulance district or political subdivision

PLACE AND TIME
9. Address where injury occurred County
10. Date of injury at o'clock M

NATURE AND EXTENT OF INJURY
11. State full nature and cause of injury
12. Has injury resulted in amputation? Yes No If yes, describe
13. On what date did you stop work because of this injury?
14. Have you returned to work? Yes No If yes, give date
15. (a) Does injury keep you from work? Yes No (b) Have you done any work during your disability? Yes No

MEDICAL CARE
16. (a) Did you receive medical care? Yes No (b) Are you now receiving medical care? Yes No
17. (a) Are you now in need of medical care? Yes No (b) Name and address of attending doctor
18. If you were treated in a hospital, give name and address

VOLUNTEER AMBULANCE WORKERS' BENEFITS
19. Have you received volunteer ambulance workers' benefits payments for the injury reported above? Yes No
20. Are you now receiving volunteer ambulance workers' benefits payments? Yes No
21. Do you claim further volunteer ambulance workers' benefits payments? Yes No If yes, explain

NOTICE
22. Have you given Notice to Liable Pol. Subdivision of Vol. Ambulance Worker's Injury or Death (Form VAW-1) to the political subdivision liable for the payment of your vol. ambulance workers' benefits? Yes No If yes, was such Notice delivered personally? Yes No or sent by Registered Mail? Yes No If yes, to whom was Notice delivered/sent Date
Name of Officer and Political Subdivision

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.

I certify that copy of this was filed with Name of Officer Title of Officer on

Political Subdivision or Ambulance Service Liable for Benefits

Dated Signed by Volunteer Ambulance Worker or

Signed A person on his/her behalf, or in case of death, by any one or more of his/her dependents, or person on their behalf. Relationship Telephone No.