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	Then give to
a. County	a. Clerk of the Board of Supervisors
b. City	b. Comptroller or Chief Financial Officer
c. Town	c. Town Clerk
d. Village	d. Village Clerk
e. Ambulance District	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

VAW - 1 (8-97)

TO BE COMPLETED BY THE VOLUNTEER AMBULANCE WORKER

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

INJURED PERSON

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 ☐ Yes ☐ No

INJURY

8. WHERE DID INJURY OCCUR? (Specify in building, outside building, en route in ambulance, etc.)

9. CHECK ONE: ☐ THE ABOVE-NAMED VOLUNTEER AMBULANCE WORKER WAS INJURED IN THE LINE OF DUTY WHILE SERVING WITH HIS/HER OWN AMBULANCE COMPANY OR AMBULANCE DEPARTMENT. ☐ 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 ☐ Yes ☐ 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? ☐ Yes ☐ No IF YES, WHEN

18. (a) NAME AND ADDRESS OF DOCTOR

(b) NAME AND ADDRESS OF HOSPITAL

CAUSE OF INJURY

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.) ☐ Yes ☐ No (b) WAS PROTECTIVE EQUIPMENT IN USE AT THE TIME? ☐ Yes ☐ No

(c) WAS PROTECTIVE EQUIPMENT DEFECTIVE? ☐ Yes ☐ 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

PREPARATION

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

TO BE COMPLETED BY CHIEF OFFICER OR DESIGNATED SUPERIOR

NEW YORK STATE Workers' Compensation Board

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 _____ or

Volunteer Ambulance Worker

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.

VAW-3 (1-11)

TO BE COMPLETED BY THE VOLUNTEER AMBULANCE WORKER

POMCO GROUP

TO ALL ALLEGANY COUNTY EMPLOYEES CLAIMING AN OCCUPATIONAL INJURY OR ILLNESS:

New York State Workers' Compensation Law is designed to provide income and medical benefits to work-accident claimants or income benefits to their dependents, regardless of fault.

POMCO Risk Management handles all claims for Allegany County's Workers' Compensation plan.

Please note the following important items:

1. You are entitled to obtain any necessary medical treatment related to your injury or illness.
2. You may choose your own physician who is authorized by the Workers' Compensation Board and will accept workers' compensation patients.
3. You should inform your doctor and/or pharmacist to directly bill Allegany County's Workers' Compensation Plan at the following address:

POMCO RISK MANAGEMENT

POST OFFICE BOX 325

SYRACUSE, NEW YORK 13206-0325

4. You should not pay any physician and/or pharmacist directly for the treatment of your occupational injury/illness. If for any reason you receive any such billing, please feel free to submit any documentation pertaining to the reported incident directly to POMCO Risk Management for further address.
5. POMCO Risk Management will be in touch with you regarding your reported injury/illness. Please make every effort to contact your assigned claims adjuster and complete all requested paperwork. If you have questions regarding the paperwork to be completed, please contact your assigned POMCO Risk Management claims adjuster.
6. The County and POMCO Risk Management will work with you towards a full physical recovery from your occupational injury/illness claim. The County encourages you to remain in regular contact with your assigned claims adjuster, who can help you easily navigate the Workers' Compensation system.

Please do not hesitate to call POMCO Risk Management at 1-877-236-7475 if you have any questions.