CAYUGA COUNTY
VOLUNTEER FIREFIGHTER AFFIDAVIT OF INJURY

To be filled out by the volunteer within 48 hours of injury
(Submit to supervisor in charge at time of injury)

1. Volunteer Name: _____ Social Security Number: _____

   Home address: _____

   Home phone number: _____ Date of Birth: _____

2. Regular Employer (Name, Address): _____

   _____

   Did you miss any work due to this injury? NO___ YES ___: First date missed:_____

   Date Returned to work:_____Estimated Weekly Wage:_____

   Number of Days Worked per Week:_____ Employer Phone: _____

3. Date of Injury: _____ Time of Injury:_____

   Location where injury occurred: _____

   _____

   Is this a re-injury? NO_____YES_____: Date of previous injury: _____

4. Has this incident been discussed with your Supervisor? NO_____YES_____:

   Name of Supervisor, Date/Time notified: _____

5. Nature of injury (body parts affected): _____

   Was there any visible injury? NO_____ YES_____: Describe:

   _____

   Describe the injury and the object, person or substance that caused the current injury: _____

   _____

   _____

   _____

   Describe in your own words exactly how the injury happened:

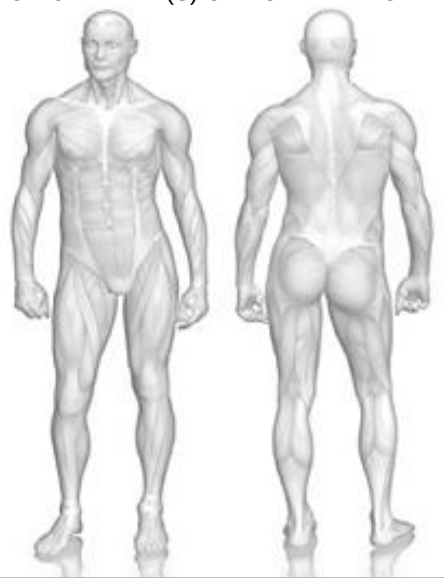
   _____

   _____

   _____

   _____

   CIRCLE PART(S) OF BODY AFFECTED:



6. Was medical care provided? NO____ YES ____: If so, when:_____

   By Whom: Provider/Doctor (Name/Address/Phone): _____

   _____

-OVER-

7. Any witnesses to the injury? NO_____ YES_____: (Please attach witness statements)

Name/Address/Phone: _____

_____

Name/Address/Phone: _____

_____

MEDICAL FRAUD DECLARATION: I hereby affirm under the penalties of perjury that the information contained above is true and correct.

Volunteer's Signature: _____ Date: _____

INSURANCE FRAUD DECLARATION: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

I understand that my signature herein constitutes my affirmation that I am applying for Worker's Compensation benefits pursuant to law, which I have made not false claims or statements or concealed any material facts in order to receive said benefits and that doing so would make me liable for civil and criminal penalties including jail.

Volunteer's Signature: _____ Date: _____

BE SURE TO SIGN BOTH THE MEDICAL AND INSURANCE FRAUD DECLARATION.

This report is to be sent by the supervisor with the VF-1 and VF-3 form to:

- **Fax to: 315-253-1369 -or-**
- **Scan and email to: payroll@cayugacounty.us -or-**
- **Cayuga County Treasurer, Attn: Payroll**
  160 Genesee Street, 5th Floor, Auburn, NY 13021

Call with any questions: 315-253-1323

Please tell all doctors and hospitals to send all medical reports and bills directly to our carrier.
(DO NOT send this form here):

New York State Municipal Workers Compensation Alliance
333 Earle Ovington Blvd., Suite 505
Uniondale, NY 11553-3624
(866) 697-6922 (phone); (516) 227-2352 (fax)

The volunteer has free choice of doctor or hospital as long as the doctor or hospital is recognized and approved by the Worker's Compensation Board. The attending Medical Doctor must submit medical reports in accordance with the Worker's Compensation Law to the N.Y.S. Municipal Workers' Compensation Alliance. The doctor or other medical providers may not submit bills to collect fees from the employee. The County has the right to have the employee examined by a doctor of their choice at a time/place reasonable to the employee. WORKER'S COMPENSATION BENEFITS WILL NOT BE PAID WITHOUT MEDICAL PROOF OF DISABILITY.