New York State Correctional Officers & Police Benevolent Association, Inc.

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If you believe that you contracted COVID-19 while on duty, and you are experiencing COVID-19 symptoms, please follow the below steps in order to ensure that you preserve your right to pursue workers' compensation and other benefits to which you may be entitled:

1. Report to your immediate supervisor that you feel ill with COVID-19-like symptoms. Follow supervisor's instructions. If you are unable to complete the below steps prior to your departure from the facility, ensure that you are provided with blank copies of the below forms prior to departure, or have a local union steward provide you with the documents as soon as possible.
2. Prior to departing the facility, complete Form 1203, entitled "Employee Accident/Injury Report," and submit it to medical staff so that medical staff can complete the health services report section. Attached is a copy of Form 1203.
3. Complete "Workers' Compensation Benefit Election Form," which is Attachment E to Directive 2208A, entitled "Workers' Compensation Benefits (Security Services)." Per the directive, completing the social security number portion of the form can be accomplished by entering the phrase "on file" in the appropriate area. Attached is a copy of Attachment E.
    a. Questions about how to fill out Attachment E? Contact Dana Betts, NYSCOPBA Workers' Compensation Specialist at 518-427-1551 x247.
4. Make copies of both Attachment E and Form 1203 and keep same for your records.
5. Submit the original Attachment E and Form 1203 to the facility personnel office. Request date-stamped copies, if the facility will provide them. If not, note the date, time, and name of the staff member to whom you submitted said forms.
6. Call NYS Accident Reporting System 1-888-800-0029 within twenty-four (24) hours and report illness.
7. Upon returning home, immediately contact your primary care physician and local health department to report your symptoms and follow their guidance. For more information on obtaining a quarantine order, see NYSCOPBA's Guidance on 'What to do if Exposed'.
8. Complete and submit C-3 "Employee Claim" form on NYS Workers' Compensation Board website: https://www.wcb.ny.gov/onlineforms/c3/C3Form.html. Save a copy of C-3 form for your records.
9. **If your facility won't accept an accident/injury form**: Send a copy of the C-3 by mail to the personnel office at your facility (within 30 days of illness/injury). Keep a copy and proof of mailing.
    a. File contract grievance alleging violation of Article 14 and 27. Include a narrative of facility's refusal to accept Form 1203 and Attachment E. Please note, you have twenty (20) calendar days (not work days) from the date the facility does not accept your Form 1203/Attachment E to file a grievance. Obtain date-stamped copies of the original grievance, if practicable. Keep copies of the grievance for your records. Coordinate

with your local NYSCOPBA representative and/or NYSCOPBA's Grievance Department, in the event you require assistance with drafting or submitting the contract grievance.

10. Keep all documents and copies of documents related to your injury in one location so that they may be easily accessed for future proceedings, if necessary to pursue your contractual and other benefits.
11. Contact your local or regional NYSCOPBA representatives to immediately inform them of any issues you may be having.

NYSCOPBA does not guarantee the success of any workers' compensation claim filed based on the above instructions. The above instructions describe how to preserve your rights as a NYSCOPBA member and New York State employee to the extent allowable by law.

NYSCOPBA is working continuously to provide updates for our members as often as possible. The above-provided information is based on what we now know. As the COVID-19 situation develops, NYSCOPBA will continue to provide information and guidance in a timely manner.

FORM 1203 (02/15) STATE OF NEW YORK - DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

EMPLOYEE ACCIDENT / INJURY REPORT

DELIVER THIS REPORT TO PERSONNEL WITHIN 24 HOURS
(#1 - 14 to be completed by Employee)

Personnel use Only (check one) ☐ Lost Time ☐ No Lost Time

1. Facility		2. Date of Accident
3. Time of Accident	4. Place of Accident	
5. Employee Name		6. Title
7. Employee Work Location	8. Shift	9. Pass Days
10. Employee remained on duty? Yes ☐ No ☐		11. Employee required medical attention? Yes ☐ No ☐

12. Statement of Employee

Note: Secondary Employment: A preexisting authorization for outside employment will be automatically reviewed for any period of time that an employee is on a Limited Duty assignment or absent from work as a result of an illness or injury (see Directive #2218, "Outside Employment").

13. Signature of Employee: _____ 14. Date: _____

15. Name of Eyewitnesses: _____

16. Statement of Supervisor: _____

17. Supervisor's Name	18. Supervisor's Signature	19. Date

FACILITY HEALTH SERVICES REPORT

20. Evaluation/Findings: _____

21. Services Provided: ☐ First Aid/Assessment ☐ Medical Treatment: _____

22. Personal Physician of Injured Employee: _____ Phone No.: _____

Address: _____

23. Date Injury Reported to Medical Unit: _____ 24. Time: _____

25. Signature: _____ 26. Title: _____

Distribution: White – Personnel Canary – Fire/Safety Officer Pink – Employee

WORKERS' COMPENSATION BENEFIT ELECTION FORM

New York State Council 82, NYSCOPBA or PBA of NYS Negotiated Agreements

To be completed by employee

INSTRUCTIONS: Please complete this form and submit it to your agency each time you file an accident report.

☐ Agency Police Services Unit

☐ Security Services Unit

☐ Security Supervisors Unit

Name	Social Security Number X X X – X X – _ _ _ _
Street Address	Home Telephone Number
City or Post Office State Zip Code	Date of Accident

I elect the following benefit program for all absences related to this accident:

1. **New York State Workers' Compensation Law Coverage only** ☐ Yes ☐ No
   I understand that if I elect the Law coverage only I will be placed on leave without pay for all absences related to this accident and I will receive only the benefits provided by the New York State Workers' Compensation law.

2. **Workers' Compensation Leave Benefit Program** ☐ Yes ☐ No

   I understand that if I elect the Leave Benefit Program, in addition to Law coverage, I will be eligible for the benefits as provided in the Council 82, NYSCOPBA or PBA of NYS negotiated agreements which include up to 6 months of paid leave, and use of credits and sick leave at half pay, if eligible. I also understand that to receive these benefits I must participate in the medical evaluation and limited duty components of this Program.

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

The information which you are being asked to provide on this form is being requested pursuant to Article 14 of the Council 82, NYSCOPBA or PBA of NYS negotiated agreements for the principal purpose of determining whether you quality for employer-provided workers' compensation benefits and will be maintained by the Personnel Office in the agency or facility in which you are employed. Failure to provide this information may result in delay of processing benefits. This information will be used in accordance with Section 96 (1) of the personal Privacy Protection Law particularly subdivisions (b), (d), and (e). For further information relating only to the personal Privacy protection Law, contact your personnel Office.

Signature	Date