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)