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Friday, June 14, 2013 11:56 AM
Duffy, Daniel
Torres Rojas, Genara; Van Duyne, Sheree
Freedom of Information Online Request Form

Information:

First Name: Iris
Last Name: Jurado
Company: Dillon Horowitz & Goldstein LLP
Mailing Address 1: 11 Hanover Square
Mailing Address 2: 20th Floor
City: New York
State: NY
Zip Code: 10005
Email Address: ijurado@dhgattorneys.com
Phone: 212-248-4900
Required copies of the records: Yes

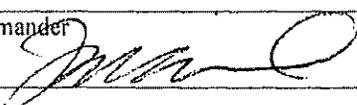
List of specific record(s):

Accident reports, photographs, witness statements, and any and all documents concerning Timothy Nerney and the incident on August 11, 2011 at the location known as Freedom Tower, 1 World Trade Center.

INSTRUCTIONS: To be prepared by reporting officer on assist cases that are not covered by other forms such as PA 116, PA 621, etc. Send original to claims attorney and copy to police desk.

CASE # 125-11

FACILITY: WTC

Full Name Timothy O Nerney		Sex M	Age 49	Date 8/11/11	0924	<input type="checkbox"/> AM <input type="checkbox"/> PM
Address Ex: (1)					Telephone Number Ex: (1)	
P.A. Property <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Place of Occurrence WTC Site Tower One 49 th Fl.		Exact Location of Subject Subject was lying down on		
Other Than P.A. Property: (Name & Address of Owner or Lessee)						
How Did Subject Arrive at Location Subject arrived by walking						
Subject: <input type="checkbox"/> Accompanied By: Name - <input type="checkbox"/> Alone Address -						
MEDICAL DATA	<input type="checkbox"/> No Treatment		<input checked="" type="checkbox"/> First Aid at Scene		By EMT Alber (Concentra)	
	Ambulance Called <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Time 0925	<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	Ambulance Responded 0938	<input type="checkbox"/> AM <input type="checkbox"/> PM
	Hospital (if hospital not listed please write-in hospital name) Bellevue Hospital				Attending Physician	
	Disposition Aided was taken to Bellvue Hospital					
Local Police (Identify): PAPD						
Witnesses (Names & Address: If None, State So) NONE						
At the above time date and place of occurrence aided was injured while operating a hoist on the 49 th floor of Tower One Ex: (1) First Aid was provided by on site EMT Alber from Concentra and ESU Truck 5. Aided was taken by ambulance to Bellvue Hopsital for further evaluation.						
Tour Commander 		Date 8-13-11	Reporting Officer and Shield # PO S. Amc #12599			

Incident Details: ID 2559

Posted by: Donald Alber

Date & Time of Incident: 8/11/2011 9:15 AM

First Name: Timothy

Last Name: Onerey

Craft:

Supervisor:

Foreman: Dennis Chatfield

Shift: 1st - 7:30am

Contractor: Tishman

Sub-Contractor: ThyssenKrupp Elevator Corp

Package: One World Trade

Location: Tower 1 49th floor

Injury Type:

Body Part(s): Leg

Side of Body: Left

Description of Incident:

Rope used to hoist elevator rails slipped/broke

Description of Treatment:

Ex. (1) stabilized and remove from
elevator shaft. Transported to belevue hospital via fdny ambulance 01B.

Notes / Follow-up:

CLAIM# Tow 000000607



EMPLOYER'S REPORT OF WORK-RELATED INJURY/ILLNESS

State of New York - Workers' Compensation Board

C-2

If one of your employees has a work-related injury or illness, you must complete and file this form within 10 days of the injury/illness or be subject to a penalty. For additional information on filing this form please refer to Workers' Compensation Law Section 110 at the end of this form. Type or print neatly.

WCB Case Number (if you know it): _____ Date of Injury/Illness: 8 / 11 / 11

Carrier Case Number (if you know it): _____ Date of this Report: 8 / 12 / 11

A. EMPLOYER INFORMATION

- 1. Employer: ThyssenKrupp Elevator 2. Employer FEIN: _____
3. Mailing Address: 5701 Pine Island Road Suite 390 Tamarac, FL. 33321
4. Location Address (if different): _____
5. Phone Number: () _____ 6. Nature of Business or Industry Code: Elevator repair and installation
7. OSHA Case Number (if known): _____ 8. NY UI Employer Reg Number: _____

B. INSURANCE CARRIER / SELF-INSURED EMPLOYER

If individually self-insured, enter your Board W Number and skip to Section C.

- 1. Board W Number: W _____ 2. Carrier/Group Name: _____
3. Policy Number: _____ Policy Period: From: ___/___/___ To: ___/___/___
4. If Carrier Unknown, Insurance Agent Name: _____ 5. Phone Number: () _____

C. EMPLOYEE'S PERSONAL INFORMATION

- 1. Name: TIMOTHY O NERNEY 2. Date of Birth: _____
3. Mailing Address: _____ EX. (1)
4. Social Security Number: _____ Ex. (1) 5. Contact Phone Number: _____ Ex. (1) 6. Gender: [X] Male [] Female

D. EMPLOYEE'S INJURY OR ILLNESS

- 1. Time of day employee began work on date of injury: 7:00 [X] AM [] PM 2. Time of injury: 9:20 [X] AM [] PM
3. Has the employee given you notice of injury/illness? [X] Yes [] No
If yes, notice was given to: _____ [] orally [] in writing Date notice provided: ___/___/___
If available, attach a copy of the employee's written notice and medical notes, and the employer's incident report.
4. Have you given the employee a Claimant Information Packet? [] Yes [X] No If yes, give date: ___/___/___
5. Where did the injury/illness happen (e.g., 1 Main St., Pottersville, at the front door): 49FL Cell #5 2 WTC
6. Was this location where the employee normally worked? [X] Yes [] No If no, why was the employee there? _____
7. Employee's supervisor: _____ 8. Did supervisor see injury happen? [] Yes [X] No [] Unknown
9. Did anyone else see the injury happen? [] Yes [X] No [] Unknown If yes, give name(s): _____
10. What was the employee doing when he/she was injured or became ill? (e.g., unloading a truck, stocking a shelf, typing annual report)
Running a Capstar hoist from a false cab.

EMPLOYEE'S NAME: Timothy O Nenny DATE OF INJURY/ILLNESS: 8/11/2011
First MI Last

D. EMPLOYEE'S INJURY OR ILLNESS continued

11. How did the injury/illness occur? (e.g., the employee tripped over a pipe and fell on the floor) _____

Running a ~~capstan~~ Capstan hoist from a false cat

12. Explain fully the nature of the employee's injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

Left Leg

13. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? Yes No If yes, what was it? _____

14. Was the injury the result of the use or operation of a licensed motor vehicle? Yes No

If yes, employee's vehicle employer's vehicle other vehicle License plate number (if known): _____

If employer's vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

15. Did the injury/illness result in the employee's death? Yes No If yes, what was the date of death? ____/____/____

Name and address of the nearest relative: _____

E. MEDICAL TREATMENT

1. What was the date of the employee's first treatment? 8/11/2011 None received Unknown

2. Where did the employee receive first medical treatment for this injury/illness? On site Doctor's office Emergency Room

Clinic/Hospital/Urgent Care Hospital Stay over 24 hours Unknown

Who treated the employee and where? Bellvue Hospital - 26th & 1st Ave - NY, NY

3. Is the employee still being treated for this injury/illness? Yes No Unknown If yes, name and address of treating doctor(s): _____

4. To your knowledge, did the employee have another work-related injury to the same body part or a similar illness while working for you?

Yes No If yes, name the doctor(s) who treated the previous injuries/illnesses (if known): _____

F. RETURN TO WORK

1. Did the employee stop work because of his/her injury/illness? Yes No If yes, on what date? ____/____/____

2. Has the employee returned to work? Yes No

If yes, on what date? ____/____/____ regular duty limited duty

3. If the employee has returned to limited duty, what are his/her average gross earnings per week? _____

EMPLOYEE'S NAME: Timothy O NERNEY DATE OF INJURY/ILLNESS: 8/11/2011
First MI Last

G. EMPLOYEE'S WORK INFORMATION on the date of the injury or illness

1. Date the employee was hired: 4/26/10
2. What was the employee's job title? ELEVATOR CONSTRUCTOR
3. What types of activities did the employee normally perform at work? (Attach job description if available.) INSTALL ELEVATORS

H. EMPLOYEE'S PAYROLL INFORMATION on the date of the injury or illness

1. Employee's gross pay in an average week was: \$ 2130.00
2. Did the employee receive lodging or tips in addition to pay? Yes No If yes, describe: _____
3. Employee's job was (check one): Full Time Part Time Seasonal Volunteer Other: _____
4. Which days of the week did the employee usually work? Mon. Tues. Wed. Thurs. Fri. Sat. Sun.
5. Was the employee paid for a full day on the day of the injury/illness? Yes No
6. Did you continue to pay the employee after the injury/illness (e.g., sick leave, vacation, disability, regular salary)? Yes No

I. ADDITIONAL INFORMATION

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

The above information is true to the best of my knowledge and belief.

If prepared by the employer:

Signature of Person Preparing Form: _____ Date: ____/____/____

Print Name: _____ Title: _____ Phone Number: (____) _____

If prepared by a Third Party on Behalf of the Employer:

Signature of Person Preparing Form: [Signature] Date: 8/12/11

Print Name: Steve Finlisk Title: Safety Manager Phone Number: (546) 454-8444

Company Name and Address: ThyssenKrupp Elevator

Name & Phone Number of Person Who Provided Information Necessary to Prepare This Form: JOE MAJERSAK

Reports should be filed by sending directly to the appropriate WCB district office (DO) at the address below with a copy sent to the insurance carrier:

Albany DO - 100 Broadway-Menands, Albany NY 12241 866-750-5157 (for accidents in the following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington)
Binghamton DO - State Office Building, 44 Hawley Street, Binghamton NY 13901 866-802-3604 (for accidents in the following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)
Buffalo DO - Statler Towers, 107 Delaware Avenue, Buffalo NY 14202 866-211-0645 (for accidents in the following counties: Cattaraugus, Chautauqua, Erie, Niagara)
Rochester DO - 130 Main Street West, Rochester NY 14614 866-211-0644 (for accidents in the following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates)
Syracuse DO - 935 James Street, Syracuse NY 13203 866-802-3730 (for accidents in the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence)
Downstate Centralized Mailing - PO Box 5205, Binghamton NY, 13902-5205 for all DO's in NYC 800-877-1373; In Hempstead 866-805-3630; In Hauppauge 866-681-5354; In Peekskill 866-748-0552 (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)