STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

EMPLOYER'S REPORT OF INJURED EMPLOYEE'S CHANGE IN EMPLOYMENT STATUS RESULTING FROM INJURY

This report is to be filed directly with the Chair, Workers' Compensation Board at the address shown on reverse side as soon as the employment status of an injured employee, as reported on Form C-2 or EC-2, or on a previous Form C-11 or EC-11, is changed. Change in employment status includes return to work, discontinuance of work, increase or decrease of regular hours of work and increase or reduction of wages. **A copy should also be sent to your insurance carrier.**

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS		3. Carrier Code	4. Date of Injury	5. Claimant's Soc. Sec. No.
1. W.C.B. Case Number	2. Carrier Case Number			

	Name	Address to which notice should be sent (Give Number and Street, City, State, and Zip Code)	
6. Injured Person			Apt.No.
7. Employer			
8. Carrier			

9. Date of most recent Employer's Report filed:(check "x" & give date filed) ☐ C-2/EC-2 ☐ C-11/EC-11

10. Date of first full day employee lost from work: _____ 11. Nature of Injury:_____

_____

_____

12. Date employee returned to work: _____

13. (a) Change of employment status resulting from above injury:

Employment Status	Hours per Day	Days per Week	Earnings	Occupation
Prior To Injury				
Changed To				

(b) Date of this change in employment status:_____ (c) Remarks:_____

_____

14. Loss of time resulting from above injury since first return to work:

From (Mo., Day, Year)	To (Mo., Day, Year)	Reason

15. Is injured person still under physician's care?_____ If yes, give name of physician:_____

16. Has injured person died?_____ If yes, give date of death:_____

Name and address of nearest known relative:_____

Date of this Report_____ Tel. No._____Firm Name_____

Prepared By:_____ Official Title_____

INSTRUCTIONS TO THE EMPLOYERS

Reports should be sent directly to the Workers' Compensation Board:

New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Statewide Fax Line: 877-533-0337 *www.wcb.ny.gov*

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.