

PO Box 5205, Binghamton, NY 13902-5205

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This report is to be filed directly with the Chair, Workers' Compensation Board as soon as the employment status of an injured employee, as reported on First Report of Injury, 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 insurer.**

**Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS**

Date of Injury/Illness: \_\_\_\_\_ WCB Case #: \_\_\_\_\_

Claim Administrator Claim (Carrier Case) #: \_\_\_\_\_

**Employee Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ Line 2: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_  
 Daytime phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  M  F  X

**Employer Information**

Employer Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ Line 2: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_  
 Employer Phone #: \_\_\_\_\_ Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one):  SSN  EIN

**Insurer Information**

Insurer Name: \_\_\_\_\_ Insurer ID (W#): W  
 Mailing Address: \_\_\_\_\_ Line 2: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_  
 Insurer Phone #: \_\_\_\_\_

Date of first full day employee lost from work: \_\_\_\_\_ Date employee first returned to work: \_\_\_\_\_

Loss of time resulting from the above injury since initial date of lost time or last C-11 filed with the Board:

Loss of Time Start Date	Return To Work Date	Reason

As a result of the above injury, was there an increase or decrease in hours worked or wages paid?  Yes  No

If yes, enter status of change below:

Employment Status	Effective Date	Hours per Day	Days per Week	Earnings	Remarks
Prior to Injury					
Changed To					

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, 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.

**Prepared By:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_  
 Official Title: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Date of this report: \_\_\_\_\_

