

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

C-11

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	on - ALL COMM	IUNICATION S	HOULD INCLU	DE THESE NUME	BERS	
Date of Injury/Illness	:	_ WCB Case	#:			
Claim Administrator	Claim (Carrier Cas					
Employee Infor	mation					
Last Name:				First Name:		MI:
Mailing Address:			Line 2:			
City:		State:		Zip Code:	Country:	
Daytime phone #:				Email Address:		
Social Security #:			Date of Birth: _		Gender: \bigcirc M \bigcirc F \bigcirc X	
Employer Inforr Employer Name:	mation					
Mailing Address:				Line 2:		
City:		State:		Zip Code:	Country:	
Employer Phone #					The Tax ID # is the (check one): S	
Insurer Informa	tion					
					Insurer ID (W# _/	-
City:						
				Zip 00dc.	Country	
Insurer Phone #: _						
Date of first full day e	employee lost fror	m work:		Date em	nployee first returned to work:	
Loss of time resulting						
Loss of Time Start Date	Return To Work Date				Reason	
As a result of the abo			e or decrease in	hours worked or v	vages paid?	
Employment Status		Hours per Day	Days per Week	Earnings	Remarks	
Prior to Injury						
Changed To						-
REPRESENTATION a	s to a material fact	in the course of r	eporting, investiga	ation of, or adjusting	surer, who KNOWINGLY MAKES A FALSE S a claim for any benefit or payment under this SUBJECT TO SUBSTANTIAL FINES AND I	s chapter for the
Prepared By:						
Last Name:				First Name:		MI:
Employer Name:						
Official Title:				Phone #:		
Email Address:					rt:	