NEW YORK STATE Workers' Compensation Board

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

C-11

PO Box 5205, Binghamton, NY 13902-5205

- Web Upload Link: https://wcbdoc.xrxfs.com/login.aspx
- Email Filing: wcbclaimsfiling@wcb.ny.gov

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: New York Lumbermen's Insurance Trust Fund Insurer ID (W#): W551006

Mailing Address: 9600 Main Street Line 2: Suite Three

City: Clarence State: NY Zip Code: 14031 Country: US

Insurer Phone #: 716-759-9606

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: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

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