

**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 \_\_\_\_\_

**C-11 (1-11)**

**C-11**

**C-11**

**C-11**

**C-11**

## **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](http://www.wcb.ny.gov)*

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.