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)	Apt.No.
6. Injured Person			
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____________________