NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205
Customer Service Toll-Free Line: 877-632-4996 Statewide Fax Line: 877-533-0337

www.wcb.ny.gov

State of New York - Workers' Compensation Board

Alternative Dispute Resolution Program
Modification of Previous Report

Complete the identifying information and use the narrative portion to modify, clarify or update information reported on any previously-filed ADR form.

INJURED EMPLOYEE (First Name, Middle Initial, Last Name)		EMPLOYEE'S ADDRESS (Street No. & Name, Apt. No, City, State and Zip Code)
DATE OF INJURY	WCB CASE NUMBER	
UNION NAME & LOCAL NUMBER		
EMPLOYER'S NAME AND MAILING ADDRESS		INSURANCE CARRIER'S NAME AND MAILING ADDRESS
FILING ENTITY: ☐ Employer ☐ Carrier ☐ Other (If "Other", give name and address.)		CARRIER CASE NUMBER CARRIER ID NUMBER **W-**

NARRATIVE

Prepared by	Official Title
Date of this Report	Telephone Number & Extension