Workers' Compensation Board

PO Box 5205, Binghamton, NY 13902-5205

Fax: 877-533-0337

www.wcb.ny.gov

# State of New York - Workers' Compensation Board
# ALTERNATIVE DISPUTE RESOLUTION PROGRAM FINAL DISPOSITION OF CLAIM

**This form is to be filed with the Board within 30 days of final disposition or settlement of a claim.**

INJURED EMPLOYEE (First Name, Middle Initial, Last Name)

EMPLOYEE'S ADDRESS ( Street No. & Name, Apt. No., City, State & Zip Code)

UNION NAME & LOCAL NUMBER

WCB CASE NUMBER

DATE OF INJURY

EMPLOYEE'S SOCIAL SECURITY NUMBER

PART(S) OF BODY AFFECTED AND DIAGNOSIS - FOR DEATH CLAIMS, SO NOTE AND STATE CAUSE

AVERAGE WEEKLY WAGE

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 ID NUMBER

W-

CARRIER CASE NUMBER

COMPENSATION PAYMENTS MADE:

| Periods of Payment | | Weekly Rate | Amount |
|---|---|---|---|
| From | To | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

WAS THIS CASE THE SUBJECT OF MEDIATION OR ARBITRATION? YES - MEDIATION YES - ARBITRATION NO

IF YES, ATTACH A COPY OF ANY WRITTEN DECISION.

FINAL DISPOSITION: (CHECK ALL THAT APPLY)

☐ CONTROVERTED CASE--CLAIM DENIED. DESCRIBE BASIS:____________________

☐ SCHEDULE LOSS OF USE AWARD/DESCRIBE:____________________

☐ PERMANENT PARTIAL DISABILITY CLASSIFICATION/DESCRIBE:____________________

☐ CLAIMANT RETURNED TO WORK. DATE OF RETURN:____________________ ☐ AT PRE-INJURY WAGES ☐ AT REDUCED WAGES

☐ SECTION 32 SETTLEMENT/ATTACH COPY OF AGREEMENT

☐ OTHER/EXPLAIN:____________________

Prepared by

Date of this Report

Official Title

Telephone Number & Extension

**ADR-2** **ADR-2** **ADR-2** **ADR-2** **ADR-2**

(1-11) Prescribed by Chair Workers' Compensation Board State of New York

**SEE FILING INSTRUCTIONS ON REVERSE**

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

# FILING INSTRUCTIONS

**Form ADR-2, Final Disposition of Claim, must be filed with the Workers' Compensation Board for every case in which Form ADR-1, Alternative Dispute Resolution Program Report of Injury, was filed with the Board. Form ADR-2 must be filed within 30 days of the final resolution of a claim, as required by 12 NYCRR 314.7(a). A copy of any written mediation or arbitration decision regarding this claim is to be filed with this form. Failure to file the prescribed ADR forms with the Workers' Compensation Board in a timely manner may result in the assessment of one or more penalties and/or the revocation of the party's authorization to participate in the Alternative Dispute Resolution Pilot Program.**