Workersâ€™ Compensation Insurance Claim Form

Employee Information

Full Name

Employee ID

Phone Number

Email Address

Address

Employer Information

Company Name

Contact Person

Phone

Email

Address

Incident Details

Date of Incident

Time of Incident

Location of Incident

Describe the Incident

Were there witnesses?

If yes, list witnesses

Injury Information

Type of Injury

Body Part(s) Affected

Describe the Injury

Was medical treatment provided?

If yes, where?

Signature

Employee Signature

Date