Remote Employee Injury Workersâ€™ Compensation Form

Employee Name

Employee ID

Department

Supervisor Name

Date of Injury

Time of Injury

Location (Home Address or Location of Injury)

Describe How Injury Occurred

Type of Injury (e.g., sprain, cut)

Body Part(s) Injured

Witness(es) (if any)

Was Medical Attention Sought?

If Yes, Provide Treatment Details and Provider

Work Missed Due to Injury (Dates and Duration)

Additional Information