Workersâ€™ Compensation Claim Form

Employee Information

Full Name

Employee ID

Address

Phone

Department

Position

Incident Details

Date of Incident

Time of Incident

Location of Incident

Supervisorâ€™s Name

Describe What Happened

Describe the Injury

Witnesses (if any)

Medical Information

Was Medical Treatment Provided?

Medical Providerâ€™s Name

Description of Treatment

Signature

Employee Signature

Date