

# Workersâ€™™ Compensation Claim Form for Construction Workers

Worker's Full Name

Employee ID

Job Title

Date of Birth

Employer/Company Name

Site Location

Supervisor's Name

Date of Incident

Time of Incident

Location of Incident (on site)

Description of Incident

Description of Injuries

Medical Attention Received

Witnesses (Names & Contact Info)

Additional Information

Workerâ€™™s Signature

Date