# Workersâ€™ Compensation Claim Form

## For Delivery Drivers

## Employee Information

Full Name

Home Address

Phone Number

Email

Date of Birth

Employee ID/Number

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## Job & Employer Information

Employer/Company Name

Supervisor Name

Job Title

Start Date

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## Injury/Accident Information

Date of Injury/Accident

Time of Injury/Accident

Location (Street Address, City)

Type of Injury

Describe What Happened

Part(s) of Body Injured

Witness(es)

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## Medical Treatment

Date First Treated

Physician/Hospital Name

Describe Medical Treatment

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## Other Information

Date Reported to Employer

Did you lose time from work?

Yes No

If yes, dates work missed

Additional Comments/Information

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Employee Signature

Date