Workersâ€™ Compensation Claim Form

Healthcare Worker

Employee Information

Name

Employee ID

Position / Title

Department / Unit

Contact Number

Email

Incident Details

Date of Incident

Time of Incident

Location (Facility/Area)

Description of Incident

Cause (if known)

Injury Details

Type of Injury

Part of Body Affected

First Aid Given?

Medical Attention Sought

Witness Information

Witness Name

Witness Contact

Reporting

Date Reported

Reported to (Supervisor/Manager)

Employee Signature

Signature

Date