Workersâ€™ Compensation Claim Form Hospitality Workers

Employee Information

Name

Date of Birth

Job Title

Employee ID

Contact Number

Address

Employer Information

Employer Name

Workplace Address

Supervisor/Manager Name

Contact Number

Injury/Illness Information

Date of Injury/Illness

Time of Injury (if applicable)

Location of Incident

Describe the Injury/Illness

How did the incident occur?

Witnesses (if any)

Medical Treatment

Were you treated by a medical professional?

Name of Medical Facility/Provider

Date of First Treatment

Additional Details

Time Work Was Missed (if applicable)

Additional Comments

Declaration

Signature

Date