Workersâ€™ Compensation Claim Form for Manufacturing Workers

Employee Information

Full Name

Employee ID

Department

Position/Job Title

Contact Number

Incident Details

Date of Incident

Time of Incident

Location of Incident

Description of Incident

Injury Information Type of Injury

Body Part(s) Injured

Medical Attention Received?

Witnesses (Name & Contact)

Additional Information Supervisor Notified

Date Reported

Other Relevant Information
