

Workersâ€™™ Compensation Claim Form for Remote Workers

Employee Information

Full Name

Employee ID

Email Address

Phone Number

Home Address

Incident Details

Date of Incident

Time of Incident

Location (e.g., Home Office, Kitchen, etc.)

Description of Incident

Describe the Injury

Was anyone else involved?

Medical Attention

Did you seek medical attention?

If yes, provide details (e.g., hospital/doctor visited, treatment received)

Work Impact

Did the injury cause you to stop working?

If yes, date/time stopped and resumed work

Additional Comments