Workersâ€™ Compensation Claim Form for Retail Employees

Employee Information

Full Name

Employee ID

Address

Phone Number

Job Title/Position

Department/Store Location

Incident Details

Date of Incident

Time of Incident

Location of Incident

Describe How the Incident Occurred

Type of Injury/Injuries Sustained

Medical Information

Describe Any Medical Treatment Received

Healthcare Provider/Facility Name

Provider Address

Witness Information

Witness Name(s)

Witness Contact Information

Additional Comments

Employee Signature

Date