Workersâ€™ Compensation Claim Form

Business Information

Business Name

Business Address

Contact Person

Phone Number

Email

Employee Information

Employee Name

Employee ID/Number

Employee Address

Phone Number

Job Title

Date of Employment

Injury/Illness Details

Date of Injury/Illness

Time

Location of Incident

Describe how the injury or illness occurred

Type and part of body affected

Witnesses (if any)

Medical Information

Was medical treatment provided?

Name/Address of Treating Physician or Facility

Any follow-up care required?

Additional Comments

Signature

Date