Workersâ€™ Compensation Claim Intake Form

Employee Information

Full Name

Employee ID

Address

Phone Number

Email Address

Date of Birth

Incident Details

Date of Incident

Time of Incident

Location of Incident

Description of Incident

Injury Details

Type of Injury

Body Part(s) Affected

Medical Treatment Received

Supervisor/Manager Information

Supervisor Name

Supervisor Contact

Witnesses

Witness Name(s) and Contact Information

Additional Information

Additional Comments or Information