**Workers’ Compensation Claim Form**

**Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name:** |  | | |
| **Date of Birth:** |  | **Social Security No.** |  |
| **Address:** |  | | |
| **City/State:** |  | **ZIP:** |  |
| **Job Title:** |  | **Department:** |  |
| **Date Hired:** |  | | |

**Employer Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Company Name:** |  | | |
| **Address:** |  | | |
| **City/State:** |  | **ZIP:** |  |
| **Phone Number:** |  | **Supervisor’s Name:** |  |

**Accident / Injury Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Accident: |  | Time of Accident: |  |
| Location of Accident (worksite/department): |  | | |
| Describe how the accident occurred: |  | | |
| Type of Injury (e.g., sprain, fracture, burn): |  | Part(s) of Body Injured: |  |
| Witness(es) Name(s) and Contact: | |  |  |

**Medical Treatment**

|  |  |  |  |
| --- | --- | --- | --- |
| Was medical treatment provided? ☐ Yes ☐ No | |  | |
| Date of First Treatment: |  | Treating Physician/Clinic Name: |  |
| Address: |  | | |
| Phone: |  |  |  |

**Lost Work Time**

* Did the injury cause you to miss work? ☐ Yes ☐ No
* If yes, dates absent: From \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ To \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

**Employee Certification**

I certify that the information provided above is true and accurate to the best of my knowledge.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

**Employer Section (to be completed by employer/HR)**

* Date Employer Notified: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_
* Name/Title of Person Receiving Report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Claim Number (if assigned): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Employer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

**For Insurance Carrier Use Only**

* Date Claim Received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_
* Claim Adjuster: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_