WORKERS' COMPENSATION INSURANCE CLAIM FORM

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

Employee Information:

Employee Full Name: _____

Employee Address: _____

Employee Phone Number: _____

Social Security Number: _____

Date of Birth: _____

Injury/Illness Details:

Date of Injury/Illness: _____

Location of Injury (address/work site): _____

Describe how the injury/illness occurred: _____

Nature of Injury/Illness (body part, diagnosis): _____

Medical Treatment:

Name and Address of Treating Physician/Provider: _____

Date First Treated: _____

Is the employee still under treatment? (Yes/No): _____

Employment Details:

Job Title/Occupation at Time of Injury: _____

Date Employee Began Work for Employer: _____

Was injury/illness job-related? (Yes/No): _____

Describe any safety equipment or training provided: _____

Compensation and Payment Information:

Date Disability Began (if applicable): _____

Has employee returned to work? (Yes/No): _____

Date Returned to Work (if applicable): _____

Employer Certification:

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

Authorized Employer Signature: _____

Print Name: _____

This form is submitted under penalty of perjury that the information provided herein is true and accurate. False statements or omissions may result in penalties including denial of benefits, fines, or criminal prosecution under applicable United States laws.

EMPLOYER SIGNATURE

Signature: _____

EMPLOYEE SIGNATURE

Signature: _____