Worker's Compensation Form

Name: _____ Date: _____

Employer: _____

Contact Person: _____ Phone: _____

Date of Injury: _____ Place of Occurrence: _____

Explain Incident: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you been seen for this accident by anyone else? If so, who treated you? _____

_____

To Submit Claims:

Worker's Compensation Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Adjuster Handling Your Claim: _____

Phone: _____

Claim #: _____