# 

# Workers’ Compensation Accident Form

## Employee Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Full Name:** |  |  |  | **Date**: |  |
|  | **Last** | **First** | **M.I.** |  |  |

|  |  |  |
| --- | --- | --- |
| **Address:** |  |  |
|  | **Street Address** | **Apartment/Unit #** |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | **City** | **State** | **ZIP Code** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Phone:** |  |  | Alt. Phone: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Social Security No:** |  |  | Date Hired: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Title:** |  |  | Location/Building: |  |

## Injury Information

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of injury:** |  | **Time of injury:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Did you report this injury to your supervisor?** | **YES** | **NO** | **Name of supervisor notified:** |  |

|  |  |
| --- | --- |
| **Exact location where injury occurred:** |  |

|  |  |
| --- | --- |
| **Body parts injured:** |  |

|  |  |
| --- | --- |
| **Detailed description of how injury occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |

## Disclaimer and Signature

*This claim form must be completed only by the employee who is injured. Any missing information could lead to a delay in processing your claim.*

I certify that my answers are true and complete to the best of my knowledge.

|  |  |  |  |
| --- | --- | --- | --- |
| **Employee Signature:** |  | **Date:** |  |
| **Received by:** |  | **Date:** |  |