**Workers Compensation Form for Employees**

**Employee Information
Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_
Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employment Details
Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_
Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Hire: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_
Average Weekly Wage: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Accident Information
Date of Injury: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_
Time of Injury: \_\_\_\_ : \_\_\_\_ AM/PM
Location of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Describe How the Injury Occurred:**

**Injury Details
☐ Head
☐ Neck
☐ Back
☐ Arm/Hand
☐ Leg/Foot
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Type of Injury:
☐ Strain/Sprain
☐ Fracture
☐ Laceration
☐ Burn
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Treatment
Did you seek medical treatment? ☐ Yes ☐ No
If yes, Name of Hospital/Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Information
Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Witness Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship to Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employee Certification
I declare that the above information is true and correct to the best of my knowledge.**

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