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**

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☐ 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: ____ / ____ / _______

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