



WORKERS' COMPENSATION CLAIM INFORMATION

Should you be injured on the job, IMMEDIATELY:

- 1. Gather the following information.
- 2. Fax a copy of this form to 888-778-5039.

INJURED WORKER:

Name _____ SSN _____

Address _____

Home Phone# _____ Work Phone # _____

Sex M/F Marital Status _____ Number of Dependents _____

Date of Birth _____ Date of Hire _____

Job Title _____ Wage Information \$ _____ per hour

Regular Work Hours: From _____ To _____ Hours Per Week _____

INJURY:

Date _____ Time _____ Where _____

Witness _____ Telephone Number _____

How _____

Type of Injury (cut, burn, etc.) _____

Exact Part of Body Injured _____

Name and Address of Physician and Hospital That Treated Injury _____

Any Missed Time From Work _____ Return to Work Date _____