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 888-565-5039.

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_____

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