

WORKER INJURY COMPENSATION REPORT

Confidential Incident & Claim Documentation

REPORT REFERENCE NUMBER

DATE OF REPORT

1. EMPLOYEE INFORMATION

FULL NAME

EMPLOYEE ID

JOB TITLE / OCCUPATION

DEPARTMENT / DEPARTMENT CODE

PHONE NUMBER

SUPERVISOR NAME

2. INCIDENT DETAILS

DATE OF INCIDENT

TIME OF INCIDENT

EXACT LOCATION OF INCIDENT

DESCRIPTION OF INCIDENT (HOW DID IT HAPPEN? WHAT TOOLS/MACHINERY WERE INVOLVED?)

WITNESSES (NAMES AND CONTACT INFORMATION)

3. INJURY AND MEDICAL DETAILS

NATURE OF INJURY / ILLNESS (E.G., CUT, BURN, FRACTURE, STRAIN)

AFFECTED BODY PART(S)

WAS FIRST AID ADMINISTERED ON SITE?

Yes

No

FIRST AID PROVIDER NAME

PHYSICIAN / HOSPITAL NAME

4. COMPENSATION & CLAIM DETAILS

ESTIMATED LOST WORK DAYS

CLAIM STATUS

Pending

Approved

Denied

TYPES OF COMPENSATION CLAIMED

Medical Expenses

Lost Wages

Disability Benefit

Rehabilitation Cost

Other

5. SIGNATURES AND AUTHORIZATION

EMPLOYEE SIGNATURE

DATE

AUTHORIZED REPRESENTATIVE / HR SIGNATURE

DATE