EMPLOYEE COMPENSATION CLAIM RETURN FORM

Worker's Compensation Board / Risk Management Division

1. EMPLOYER INFORMATION

Employer / Company Name

Policy Number

Address

Contact Person & Title

Phone Number

Email Address

2. EMPLOYEE INFORMATION

Full Name

Employee ID / SSN

Date of Birth

Address

Phone Number

Job Title / Occupation

Department

Date of Hire

3. INCIDENT & INJURY DETAILS

Date of Incident

Time of Incident

Date Reported to Employer

Exact Location of Incident (e.g., building, floor, department)

Describe how the injury/illness occurred (what was the employee doing?)

Describe the nature of the injury/illness (specify body parts affected)

4. MEDICAL INFORMATION

☐ First Aid Only (on-site) ☐ Emergency Room / Hospital ☐ Clinic / Physician's Office

Physician / Medical Facility Name

Facility Phone Number

5. COMPENSATION & WORK STATUS

Did the employee lose time from work?

☐ Yes ☐ No

Last Day Worked

Return to Work Date

Weekly Earnings (Gross)	Hours Per Week	Hourly Rate of Pay

6. AUTHORIZATION & SIGNATURES

By signing below, the parties certify that the information provided in this claim return report is true, accurate, and complete to the best of their knowledge. Any false or misleading statements may lead to prosecution or denial of benefits.

Employee Signature

Date

Employer Representative Signature

Date

For Office Use Only. Please return the completed and signed form to your HR Department or Workers' Compensation Representative.