Workman's Compensation Form

You <u>must</u> notify your employer of any on-the-job injury or illness in order for this claim to be processed. Failure to do so makes you personally responsible for payment!

All information below must be filled in accurately:

Patient Name _____

Home Address _____

City, State, Zip _____

Home Telephone _____

Date of Birth _____

Social Security Number _____

Employer's Name _____

Employer's Address _____

City, State, Zip _____

Employer's Phone number _____

Supervisor/Contact Name _____

Have you filed an accident report with your employer? _____

Date of Injury _____

Please describe how your injury occurred.

_____

_____

_____

_____

_____

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_____

_____

I understand that my failure to report my on-the-job injury or illness to my employer could make me personally responsible for payment.

Signed _____ Date _____