Workers-Compensation Claim Notification

Worker Details

Worker Name*: _____

Employee/Payroll ID: _____

Date of Birth: _____

Residential Address: _____

_____

Phone Number: _____

Email: _____

Job Title/Position: _____

Employment Type: _____ > *Options: Full-time, Part-time, Casual, Contractor, Other*

Employment Start Date: _____

Shift at Time of Incident: _____ > *Options: Normal shift, Overtime, On-call, Other*

Incident Details

Date of Incident*: _____

Time of Incident: _____

Location of Incident: _____

Description of Incident*: _____

_____

Immediate Actions Taken: _____

_____

Injury Details

Part of Body Injured*: _____

Nature of Injury*: _____

Cause/Mechanism of Injury: _____

Initial Treatment Provided: _____

_____

Level of Medical Treatment: _____ > *Options: None, First Aid Only, Doctor/GP, Hospital Outpatient, Hospital Inpatient, Other*

Treating Medical Provider Name: *(Fill only if applicable)*

_____