Workers’ Compensation Claim (Verified by Employee)

Personal Details

First Name :	
Last Name :	
Date Of Birth:	Gender :
Home Phone :	Mobile Phone :
Email :	
Address :	
City :	State :
Zip/Postal Code :	Country :

Injury Details

I stopped work due to the injury :
I received medical treatment for the injury :
Nature of Injury :
Incident and Injury Details :
Employer at Time of Injury :
Date and Time of Injury :
Date and Time I Stopped Work :
Date and Time Injury Was Reported to Employer:

Employment Details

Occupation and Typical Work Activities :	
Employer :	
Still Employed by Employer :	Employment Type :
Employment Start Date :	Income Frequency :
Income :	

Certificate of Capacity

Type of Injury :	
Work Capacity :	
From Date :	To Date :
Healthcare Provider :	
Healthcare Provider Phone :	Issued Date :

Acknowledgment

I certify that the information that I've provided is true, correct, and complete to the best of my knowledge. I understand that knowingly giving false information may result in a fine, imprisonment, or both, and that I must pay back any benefits received on the basis of the false information. I understand that by typing my name, I am signing this application.	
Signature :	Date :