



## **WORKERS' COMPENSATION CLAIM INFORMATION**

Should you be injured on the job, IMMEDIATELY:

1. Seek appropriate medical attention
2. Gather the following information
3. Email this form to WC@medicalsolutions.com

### ***INJURED WORKER:***

Name \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone# \_\_\_\_\_ Work Phone # \_\_\_\_\_

Sex M/F Marital Status \_\_\_\_\_ Number of Dependents \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date of Hire \_\_\_\_\_

Job Title \_\_\_\_\_ Wage Information \$ \_\_\_\_\_ per hour

Regular Work Hours: From \_\_\_\_\_ To \_\_\_\_\_ Hours Per Week \_\_\_\_\_

### ***INJURY:***

Date \_\_\_\_\_ Time \_\_\_\_\_ Where \_\_\_\_\_

Witness \_\_\_\_\_ Telephone Number \_\_\_\_\_  
\_\_\_\_\_

How \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Type of Injury (cut, burn, etc.) \_\_\_\_\_

Exact Part of Body Injured \_\_\_\_\_

Name and Address of Physician and Hospital That Treated Injury \_\_\_\_\_  
\_\_\_\_\_

Any Missed Time From Work \_\_\_\_\_ Return to Work Date \_\_\_\_\_