Occupational Injury Claim Form

Employee Information

Full Name:

Employee ID:

Department:

Contact Number:

Injury Details

Date of Injury:

Time of Injury:

Location of Incident:

Description of Accident and Injury:

Medical Attention

Was medical treatment provided?

Yes No

If yes, where was treatment provided?

Additional Information

Name of Witnesses (if any):

Employee Signature:

Date Submitted:

Submit Claim