Workers' Compensation trust®
P.O. Box 5042
Wallingford, CT 06492
(203) 678-0100

CLAIM #

CLAIMANT'S REPORT OF INJURY

Your employer has reported an occupational injury. Please assist us in processing your claim by completing the information requested below and returning this form to us.

NAME:	HOME PHONE:
ADDRESS:	WORK PHONE:
CITY/STATE/ZIP:	INJURY DATE:
IMMEDIATE SUPERVISOR:	DATE OF HIRE:
OCCUPATION:	MARITAL STATUS:

NAME AND ADDRESS OF ADDITIONAL EMPLOYER:

DESCRIBE THE ACCIDENT:

NAME OF WITNESSES:

DESCRIBE THE INJURY:

HAVE YOU EVER INJURED THE SAME BODY PART? YES ☐ NO ☐

IF YES, PLEASE EXPLAIN

NAME AND ADDRESS OF YOUR DOCTOR:

NAME AND ADDRESS OF HOSPITAL:

DATE YOU RETURNED TO WORK: IF STILL DISABLED, EXPECTED DATE OF RETURN TO WORK:

IF YOU WERE PRESCRIBED MEDICATION, PLEASE INDICATE NAME:

Please indicate your normal work schedule below: # hours per week:

Sunday	Monday	Tues	Wednesday	Thurs	Friday	Saturday

I acknowledge that this information is true to the best of my knowledge and understand that any person who intentionally misrepresents or fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Signature Date