Employee Claim Form for Accident Compensation

Please complete all sections of this form to ensure timely processing of your accident compensation claim.

Employee Name:

Employee ID/Number:

Department/Division:

Job Title/Position:

Date of Accident:

Time of Accident:

e.g., 2:30 PM

Location of Accident:

Description of Accident:

Briefly describe what happened

Description of Injury/Injuries Sustained:

Names of Witnesses (if any):

Was medical attention sought?

Yes/No. If yes, provide details

Number of workdays lost (if any):

Additional Information (if any):

Employee Signature:

(Type name for digital signature)

Date:

Submit Claim