Workers' Compensation Occurrence

Fax Notification with No Medical Treatment Requested

Please fax to (609) 631-7736

☒ NO TREATMENT REQUESTED

Completed By Name and Title:			Phone Number:
CLAIMANT INFORMATION			
Name (Last, First, Middle)			
Date of Birth	Social Security #		
Address (Include zip code)			
Gender ☐ Male ☐ Female	Occupation/ Title		
Home Phone Number		Cell Phone Number	
EMPLOYER INFORMATION			
Employer Name			Phone Number
Address (Include zip code)			
OCCURRENCE INFORMATION			
Date of Occurrence	Time of Occurrence ☐am ☐ pm		Date employer notified
Location/department where occurrence occurred:			
Describe how the incident occurred:			
List affected body part/s			☐ Left ☐ Upper ☐ Right ☐ Lower
Employee Signature			Date