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	
EMPLOYLER 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 ☐Right	☐Upper ☐Lower
Employee Signature			Date	