EMPLOYER'S WORKERS COMPENSATION CLAIM REPORT

Please send claim report to:
Danielle Azicri
Risk Management Coordinator
Phone Number:814- 451-6292
Fax: 814-451-6484
Email: dazicri@eriecountygov.org

County of Erie
140 West Sixth Street
Erie, PA
United States
16501
Phone: 814-451-6292
Fax: 814-451-6484
www.eriecountygov.org

Employee Name:

Address:

SS Number:

Phone Number :

Type of Employment

- ◯ **Full-Time**
- ◯ **Part-time**
- ◯ **Per Diem**

Marital Status

- ◯ **Single**
- ◯ **Married**

Dependents

How many?

Male/Female:

◯ **Male** ◯ **Female**

Last day Worked:

Date Disability Began:

Date Returned to Work:

City/State/Province:

Zip/Postal Code:

Date of employment:

Job Title:

Department:

Date of Injury:

Time of Injury:

What time did EE begin work?

Did Injury or Illness occur on the Employer's Premises?

◯ **Yes** ◯ **No**

If no, where?

Did you seek medical treatment?

Where?

Type of Injury or Illness:

Part of Body Affected:

Cause of Injury:

Equipment used during Injury:

Name, Title, & Number of person completing this form