



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 <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> am <input type="checkbox"/> pm	Date employer notified
Location/department where occurrence occurred:		
Describe how the incident occurred:		
List affected body part/s	<input type="checkbox"/> Left <input type="checkbox"/> Upper <input type="checkbox"/> Right <input type="checkbox"/> Lower	
Employee Signature	Date	