



## Workers Compensation Notice of Claim Filed

<b>Employee:</b>
<b>Employer Name and Address:</b>
<b>Employer Phone#:</b>
<b>Date of Claimed Injury/Accident:</b>
<b>Insurance Carrier:</b>
<b>Insurance Carrier's Phone#:</b>
<b>Date First Report of Injury sent to Insurer:</b>

To Human Resources Department,

Your employee, \_\_\_\_\_, has reported to our office for examination and treatment due to an injury sustained on the job and states that you are the employer. This office needs verification. Please give your employee of copy of the **First Report of Injury** form to provide to his/her doctor.

Minnesota's Worker Compensation law requires that any injury incident reported by an employee must be documented in writing. A First Report of Injury is required to be completed by the employer and to be filed with the employer's Worker's Compensation insurance carrier irregardless of whether the employee continues to seek medical attention. The decision to accept or deny responsibility for an injury claim shall be determined by the employer's insurer.

Please sign and return this notification to our office. If you could please include a description of this person's job it may aid us in getting them back to work as soon as possible.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_