C.C.T. Workers' Compensation

21 Colville Street | P.O. Box 150, Nespelem, WA 99155
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Employee Application for Injury or Occupational Disease Form

APPLICANT INFORMATION

Emp. Name: ______________________ Mailing Address: ______________________
Phone/Cell: ______________________ Email: ______________________
Date of Birth: ______________________ S.S.N #: ______________________
Marital Status: ______________________ Dependent(s) & DOB: ______________________
Dependent(s) & DOB: ______________________ Dependent(s) & DOB: ______________________

EMPLOYMENT

Department: ______________________ Job Title: ______________________
Date of Hire: ______________________ Hourly Wage: ______________________
Work Schedule: ______________________ Work Hours: ______________________
Did you lose any time from work beyond date of injury / accident? (Yes) (No)
Last Day Worked: _____/_____/_______ | Date Returned to Work: _____/_____/________

INJURY / ACCIDENT REPORT

Incident Date: ______________________ Incident Time: _____:_____ (A.M.) / (P.M.)
Incident Location: ______________________ Bodily Injury Location(s): ______________________
* Injury /accident was reported to Immediate Supervisor on (DATE) : _____/_____/_______
1.) Were you preforming job duties? (Yes) (No)
2.) Was injury / accident the fault of another employee? (Yes) (No) | Name(s): ______________________
List any witnesses:
Part of body injured or exposed: ☐ Right ☐ Left
Describe in detail how your injury occurred:

MEDICAL

Please complete this section if you received medical treatment for injury / accident

Physician Name/Clinic Name:
Address:
Phone:

Notice: Indian reservations are sovereign nations and are not subject to the state or federal workers' protection laws.

Employee Signature: ______________________ **Date**: ______________________

DISCLAIMER & SIGNATAURE

I declare that the foregoing information & statement supplied are true to the best of my knowledge

Employee Signature: ______________________ **Date**: ______________________

IMMEDIATE SUPERVISOR SIGNATAURE

Supervisors Signature: ______________________ **Date**: ______________________