Print Reset

EMPLOYEE'S REPORT OF CLAIM

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

1. Social Security Number	2. Date of Injury		3. Date of Birth (MM/DD/YYYY)	4. Employee Telephone Number	
5. Employee Name (Last, First, MI)			6. Employer Name		
7. Employee Street Address			8. Employer Street Address		
9. Employee City	10. State	11. ZIP Code	12. Employer City	13. State	14. ZIP Code
15. Describe the type of injury and explain how it happened. (If a medical report is available, please attach a copy.)					
16. Are you making a claim for payment of medical expenses? ☐ Yes ☐ No If yes, please attach a copy of medical bill(s) if available.			17. Last Day Worked		
18. Have you gone back to work? ☐ Yes ☐ No If yes, date of return _____/_____/_____			19. Was the injury reported to your employer? ☐ Yes ☐ No If yes, date reported _____/_____/_____		

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

20. Employee Signature	21. Date of this report

OFFICE USE ONLY

Carrier Name

The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.	Authority: Workers' Disability Compensation Act, 408.31(4) Completion: Voluntary Penalty: None