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EMPLOYEE'S REPORT OF CLAIM

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
P.O. Box 30016, Lansing, MI 48909

NOTE: A copy of this form will be sent to your employer and their workers' compensation insurance carrier. Do not submit any medical reports with this form.

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)			10. Employer Name		
6. Employee Street Address			11. Employer Street Address		
7. Employee City	8. State	9. ZIP Code	12. Employer City	13. State	14. ZIP Code
15. Describe the type of injury and explain how it happened.					
16. Are you making a claim for payment of medical expenses? ☐ Yes ☐ No			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

LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.	Authority: Workers' Disability Compensation Act, 408.31(4) Completion: Voluntary Penalty: None

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