D & H Alternative Risk Solutions
Worker's Compensation Claims
Ph: (973) 940-1851
Fax: (973) 940-1852
Contact Person:
Kathleen Guze - Ext. 238

Workers' Compensation Occurrence

Fax Notification with No Medical Treatment Requested

Please fax to 973-940-1852

☒ 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 ☐ Male ☐ 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 ☐ am ☐ pm	Date employer notified
Location/department where occurrence occurred:		
Describe how the incident occurred:		
List affected body part/s		☐ Left ☐ Upper ☐ Right ☐ Lower
Employee Signature		Date