

Volunteer Injury Compensation Request Form

Volunteer: Complete this form and return it to your supervisor. Please attach a copy of your medical bill(s).

Last Name _____ **SSN** _____ - _____ - _____

First Name _____ **M.I.** _____ **Date of Birth** _____

Home Address _____ **Home Telephone** _____

_____ **Work Telephone** _____

Type of injury (e.g. sprain, cut) _____ **Date of Injury** _____

Department you were volunteering for _____

Compensation Requested \$ _____

Name of the Doctor that saw you _____ **Date of Doctor visit** _____

Facility you received medical attention from _____

Name of your primary insurance _____

Volunteer's Signature _____ **Today's Date** _____