Form AR-C	ARKANSAS WORKERS' COMPENSATION COMMISSION	C
Authority: Ark. Code Ann. § 11-9-702 Revised: 1-1-2001	324 Spring Street, Little Rock, AR 72201 Mail: P.O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

CLAIM FOR COMPENSATION

EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	MI	Social Security Number	Date of Birth	(Area Code) Home Phone No.

Street Address or P.O. Box	City	State	Zip Code

EMPLOYER INFORMATION (Please Print)

Employer's Name (name under which doing business)	(Area Code) Employer's Telephone No.

Employer's Street Address	Employer's City	State	Zip Code

ACCIDENT INFORMATION (Please Print)

Employer's Workers' Compensation Insurance Carrier (if known)	Place of Accident (City, State)	Date of Accident

Briefly describe the part of body injured and cause of injury: _____

CLAIM INFORMATION (Please Print)

If this claim is for **initial** benefits (no benefits, either medical or indemnity, have been received), what compensation benefits are you claiming?

☐ Temporary Total Disability ☐ Temporary Partial Disability ☐ Permanent Partial Disability ☐ Permanent Total Disability

☐ Rehabilitation ☐ Attorney Fees ☐ Medical Expenses ☐ Other (Explain):

If this claim is for **additional** benefits, what specific benefits are you claiming?

☐ Additional Temporary Total ☐ Additional Temporary Partial Disability ☐ Additional Permanent Partial ☐ Additional Medical Expenses

☐ Rehabilitation ☐ Attorney Fees ☐ Other (Explain):

If employee is deceased and claim is for death benefits, list name and address of all persons claiming death benefits: _____

List any person or entity (with address and phone number) which has paid any benefits under a group health, disability or loss of income policy for the injury you are reporting on this form: _____

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, written or oral, including, but not limited to, copies of medical records, concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician and psychotherapist patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original.

Date _____ Signature _____

If claimant is represented by an attorney, that legal representative must sign below pursuant to Ark. Code Ann 11-9-717.

_____ _____

Name and Address of Attorney Signature