Workers' Compensation Employee Statement

Supervisors should provide all injured employees with this form to complete concerning the accident/ incident. This form should be completed in its entirety and should be an accurate and truthful account of the accident/ incident. This form should be completed by the employee only. If an employee is unable to complete this form or requires assistance, the Supervisor must also sign Section B.

SECTION A: EMPLOYEE STATEMENT

First Name _____ Middle _____ Last Name _____ Employee ID _____

Department _____ Division/Unit _____

Work Location _____ County _____

Date of Injury _____ Date Injury Reported _____

Name and Title of Person Notified of Injury _____

Were there any witnesses to the accident/ incident? ☐ Yes ☐ No

If yes, please provide the names and department of all known witnesses

_____

_____

Part(s) of the body injured _____

Prior to this accident/incident, have you ever hurt, suffered injury , or received treatment for the body part(s) listed in question above? ☐ Yes ☐ No

If yes, please provide the date of prior injury, type of injury, names of treating physician or practice group.

_____

_____

_____

Description of Accident

_____

_____

_____

_____

_____

_____

Cause of Accident

_____

_____

_____

_____

Workers' Compensation Employee Statement (Continued)

SECTION B: EMPLOYEE AND SUPERVISOR CERTIFICATION

I hereby certify that the above referenced information is true and accurate. I further understand that the information above will be used by my employer to help determine compensability for my injury and that any inaccurate or false statements offered may result in a delay in processing my claim and/or denial of my request for Workers' Compensation Benefits.

Employee Signature _____ Date _____