WORKERS' COMPENSATION

Employee Statement & Supervisor's Report of Accident

EMPLOYEE STATEMENT

Name _____Age_____Phone_____SS #_____
Address_____

What is your Job Title? _____What are your work hours? _____
Date of injury: _____Time of injury: _____
Location of where injury occurred: _____
Reason for being at that location:_____
_____
Explain in detail exactly how the accident/injury occurred:_____
_____
_____
Did anyone or anything contribute to this incident?_____
Did anyone witness this incident?_____
Name: _____Job Title:_____
Name: _____Job Title:_____

List all body parts injured: _____
Have you ever been treated for any of these body parts in the past? Yes No
If yes, provide the date(s) last treated:_____ Did you require surgery? Yes No
Did you have an MRI or other diagnostic testing? Yes No
Are you employed elsewhere? Yes No If yes, where_____
Address_____
What do you do there? _____Hours:_____
_____

Employee Signature_____**Date**_____

Supervisor Witnessing Signature_____ **Date**_____

SUPERVISOR STATEMENT

Name_____Department_____

Was the employee following their job description?_____

Is additional training needed?_____

Was the accident preventable? _____

Recommendation to prevent this type of accident in the future_____

Based on your knowledge of the incident, do you agree or disagree with employee's statement? Yes No
_____

If you have additional information regarding this incident, after you have completed your inquiries, please provide same on a separate page and include the employee's name and date of injury.

Supervisor Signature_____ **Date**_____