"EMPLOYEE" - STATEMENT OF INJURY OR ILLNESS

EMPLOYEE INFORMATION [To be completed by Employee]			
Name (First, Last)		Date of Birth / /	
Address: (Street, City, State, Zip)			
Phone Number(s): Home: ( ) Other: ( )			
Job Title:	Department:	Shift:	
Did the injury occur on the employer premises? ☐Yes ☐ No If No, Where?		LOCATION:	
Date of Accident / /	Normal Shift Start Time ☐AM ☐ PM	Time of Accident ☐AM ☐PM	Worked Until End of Shift ☐YES ☐ NO
Accident was reported to:			

Description of Injury (Describe how the injury occurred, be specific)

Part (s) of Body Injured: (check all that apply)

☐ **Arm**	☐ **Face**	☐ **Groin**	☐ **Internal Organs**	☐ **Neck**	☐ **Wrist**
☐ **Back**	☐ **Finger**	☐ **Hand**	☐ **Leg**	☐ **Elbow**	☐ **Shoulder**
☐ **Eye**	☐ **Foot/feet**	☐ **Head**	☐ **Knee**	☐ **Stomach**	☐ **Other (describe)**

Please describe the injured Body Part(s) [i.e. left foot, right thumb]:

I hereby declare that the statements provided in this document are; to the best of my knowledge and belief, complete and true.

Employee Signature: **Date:**
Original Signature Required.

Instructions:

1. Inform your supervisor, Michele Zimmerman and/or Carlie Cole of your injury. Please do not seek treatment from a school nurse. Injuries should be evaluated and treated, if necessary, by a panel physician. An ambulance will be called in the event of an emergency.
2. Complete this form and forward it directly to Michele Zimmerman and/or Carlie Cole.
3. Seek medical advice from a panel physician. Or, if you choose not to treat immediately for your injury, submit this form and the Workers' Compensation Medical Treatment Waiver Form to Michele Zimmerman and/or Carlie Cole.