EMPLOYEE'S STATEMENT OF ACCIDENT/INJURY/ILLNESS

To be completed by the employee and given to their supervisor immediately following the incident

****IMPORTANT-PLEASE COMPLETE ALL SECTIONS****

Name:			Social Security #:			
Marital Status:			Male ☐	Female ☐		
Address:			Position:			
City:	State: MD	Zip:	Status:	FT ☐	PT ☐	SUB ☐
Home Phone #:			Date of hire:			
Date of Birth:			How long at Current Job:			
School/Department:						
Location of Incident:						
Part of Body Affected (be specific):						
Date of Incident/Accident:			Time:	AM ☐ PM ☐		
Time You Reported to Work:				AM ☐ PM ☐		
Names/Addresses of Witnesses:						
Name of Immediate Supervisor:						
Date Employer Notified:			Individual Notified:			
Medical Treatment Required: Yes ☐ No ☐			Hospitalized: Yes ☐ No ☐			
Describe any Medical Treatment Received or scheduled to receive:						
Physician's Name:			Phone:			
Physician's Address:			City:	State: MD	Zip:	
Treating Hospital:						
COMPLETE DETAILS OF INCIDENT (Be as specific as possible about what happened):						
Date:			Employee Signature:			

****TO THE BEST OF MY KNOWLEDGE, THE ABOVE STATEMENT IS CORRECT****