EMPLOYEE INCIDENT REPORT

INSURANCE BROKERAGE

EMPLOYEE STATEMENT

Please complete the form and return to your employer immediately

- **Location:**
- **Address:**
- **Injured Employee Name:**
- **Date of Injury:** **Time of Injury:** ☐ am ☐ pm

ACCIDENT INFORMATION

- What were you doing at the time of accident?
- Who was around you at that time?
- Describe exactly how the incident happened?
- Was a resident involved?
- Describe where the incident happened?
- Describe the part of the body affected and the nature of the injury:

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- Describe what you could have done differently to avoid the incident:

- Have you had any prior MVA or workers' compensation claims? ☐ Yes ☐ No

- Have you ever had another injury to the same body part, or similar illness? ☐ Yes ☐ No
- If yes, were you treated by a doctor? ☐ Yes ☐ No
- If yes, provide the names and addresses of the doctor(s) who treated you:

- Was the previous injury work related? ☐ Yes ☐ No
- If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

By my signature, I certify that the above information is correct and that I have completed this form truthfully without any coercion from my employer. The information I have provided is true and accurate to the best of my knowledge. I understand that knowingly providing false information is considered fraud and may result in legal action. I further acknowledge that I am not intentionally or willfully attempting to deceive or defraud the workers' compensation system.

Dated ***Signature***