Worker's Compensation Employee Statement

Please complete this form as soon as possible no later than 24 hours after the incident or illness. It is the employee's responsibility to seek appropriate medical care by following administrative guidelines. Any employee who files a false report will be subject to the appropriate administrative action.

Section 1 – Employee Information

Last Name: _____ First Name: _____
Home Address: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
SS#: _____ DOB: _____ Gender: _____ Job Title: _____
Work Location: _____ Work Hours: _____ to _____

Section 2 – Employee Injury/Illness Information

Date of Injury or Illness: _____ Time: _____ □ AM □ PM
Building Name and Location: _____
Specific Location within Building: _____

What where you doing just before the incident occurred? (Please describe the task being performed)

What happened? (Tell us how the injury or illness occurred and any equipment being used)

What was the injury or illness? (Tell us the body part(s) affected and how it was effected)

Did anyone witness the injury? Who? _____
Did you receive any medical treatment? _____ Where? _____
Have you missed any work? _____ When? _____
Is further medical treatment needed? _____ What? _____
Who is your supervisor and their title? _____

_____ _____
Employee Signature Date Completed
The statements above are true to the best of my knowledge.

Insurance Carrier: Indiana Insurance Company; P.O. Box 6063; Indianapolis, IN 46206-6063; 800-279-7221
Policy # WC9127332

Please make a copy of the completed form for your records