Occupational Injury Statement Form

Employee Information

Name

Employee ID

Job Title

Department

Supervisor

Injury Details

Date of Injury

Time of Injury

Location of Incident

Describe How the Injury Occurred

Type of Injury

Part(s) of Body Injured

Witness Information

Witness Name

Contact Information

Medical Details

Was First Aid Provided?

Medical Treatment Location

Date Reported

Reported To

Employee Statement

Signature

Employee Signature

Date