Workersâ€™ Compensation Insurance Statement of Facts

Employer Information

Employer Name

Policy Number

Address

Phone

Employee Information

Employee Name

Date of Injury

Occupation

Incident Details

Date Reported

Location of Incident

Description of Incident

Nature of Injury or Illness

Nature of Injury/Illness

Medical Attention Provided

Witnesses

Witness Name(s)

Witness Statement(s)

Employer's Statement

Statement

Signature

Employer Signature

Date