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EMPLOYEE INJURY/ACCIDENT STATEMENT

THIS FORM IS TO BE COMPLETED THE DAY OF INJURY OR ACCIDENT

DATE OF ACCIDENT: _____

LOCATION OF ACCIDENT: _____

WITNESSES: 1._____

2._____

OTHER:_____

DESCRIBE IN YOUR OWN WORDS – IN DETAIL – HOW THE INJURY/ACCIDENT TOOK PLACE:

_____

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Is medical treatment being requested by you at this time for your injury/accident?

___ Yes ___ No

_____

Employee Signature Date

_____

Supervisor Signature Date