Employee Statement (Form)

Employee Name: _____ S.S.N.: _____
Address: _____ Date of Birth: _____
City/State/Zip: _____ Telephone#: _____
Employee's Job Title: _____ ☐ M ☐ F ☐ Part-Time
Marital Status: ☐ Unmarried ☐ Married ☐ Separated Number of Dependents: _____ ☐ Full-Time
Subscriber Location (Where you report to work): _____

Incident:

Date, Exact Time & Location where injury occurred _____

_____

Last date worked _____ Date returned _____
If not returned to work yet, what is the projected return date? _____
Date injury was reported (if different from date of injury, please explain why): _____

_____

To whom did you report the injury? _____
Nature of Injury _____
Part of body affected _____
Describe fully how incident occurred (please be specific as to tools or materials being handled; what you were doing):

_____

Is this an aggravation of a previous injury? _____ Yes _____ No
Have you ever had a similar injury? _____ Yes _____ No
Was medical attention received? _____ Yes _____ No
If yes, name and address of treating physician or hospital _____

If no: Was medical attention refused? _____ Yes _____ No
(Please sign waiver below if medical attention was refused)

I certify that the above-described injury occurred in the course of and arising out of my employment. I also certify that I have made a conscious decision not to seek medical attention. I understand that by refusing prompt medical attention, I accept all responsibility for any medical complications, aggravations, or medical problems connected to this injury.

_____ _____
Employee's Signature (to refuse treatment) Date

In order to facilitate your recovery and/or return to work from this injury, related medical information will be requested. I certify that the above-described injury occurred in the course of and arising out of my employment. By signing this form, I expressly waive all provisions of law which forbid any person or persons who heretofore did or who hereafter may medically attend, treat or examine me or who may have information of any kind which may be used to render a decision in my claim for this injury/disease of _____, _____ from disclosing such knowledge to my employer or its representatives. A reproduction of this agreement may be used in lieu of the original. Please keep in mind that any person who knowingly and with intent to defraud or deceive the Bureau of Workers' Compensation or any insurance carrier, files a statement containing false, incomplete or misleading information may be subject to criminal penalties.

_____ _____
Injured Employee's Signature Date
If employee has a back-related injury, he/she must complete second page of this form.

_____ _____
Witness Signature (to employee's signature above) Date

_____ _____
Signature of Reporting Personnel Date

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Employee Statement (Continued)

(THIS FORM IS TO BE COMPLETED AND SIGNED BY EMPLOYEE WHEN BACK INJURY IS REPORTED)

Employee Name _____

1. What part of your back hurts now? _____
2. When did you first notice this back pain (date and time)? _____
3. What did you feel? _____
4. What were you doing at that time? (Explain in detail) _____
5. If you were lifting an object, what was it and how heavy? _____
6. What was your exact position when pain was first noticed? _____
7. What was the length of time between the injury and your disability? _____
8. Did anyone see you get hurt? Give name _____
9. Did you report or mention this injury to anyone? _____

Who and when? _____

10. Did you ever have a back injury previously? _____
11. If so, when? _____ What part of your back? _____
12. Were you treated by a doctor? _____ Yes _____ No Date _____

Has it given further trouble? _____

Have you ever received or filed for compensation because of a back injury? _____

If so, list Bureau of Workers' Compensation claim number(s) _____

In order to facilitate your recovery and/or return to work from this injury, related medical information will be requested.

I certify that the above-described injury occurred in the course of and arising out of my employment. By signing this form, I expressly waive all provisions of law which forbid any person or persons who heretofore did or who hereafter may medically attend, treat or examine me or who may have information of any kind which may be used to render a decision in my claim for this injury/disease of _____, _____ from disclosing such knowledge to my employer or its representatives. A reproduction of this agreement may be used in lieu of the original.

_____ _____
Injured Employee's Signature Date

_____ _____
Witness Signature (to employee's signature above) Date

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