

# EMPLOYEE'S INJURY STATEMENT

**This form is to be completed in full by the injured employee and submitted to the Risk Management Department along with the First Report of Work Injury**

NAME\_\_\_\_\_

DEPARTMENT\_\_\_\_\_

DATE OF INJURY\_\_\_\_\_ TIME OF INJURY\_\_\_\_\_

EMPLOYEE'S INJURY STATEMENT:

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EMPLOYEE'S SIGNATURE\_\_\_\_\_ DATE\_\_\_\_\_