



Employee Injury Statement Form

Date and Time of Injury _____

Employee Name _____

Employee Position _____

Store Location _____

Reported to _____

Was this involving a Motor Vehicle Accident Yes _____ No _____

How did the injury happen? Describe: _____

What is the Body Part Injured? _____

Will you seek Medical Treatment Yes _____ No _____

Employee Signature

Date

Manager Signature

Date