Town of Brunswick

Employee's Statement

Reported Work-Related Injury

Name_____ **Date** of Injury_____
Time of Injury_____
Social Security #_____ **Hour Started Work**_____
Street Address _____
Home Phone # _____ Date of Birth _____Age_____
Name of direct supervisor _____

Do you have any other employment? **___ Yes (fill out the employment form)**
___ No

How did this injury / illness happen?

_____
_____
_____

Where did this accident happen?

_____
_____

Where on your body were you injured? (state the exact location and nature of the injury)

_____
_____
_____

Were you treated for the above? ___ yes ___ no Date of treatment _____
If yes, list all doctors and hospitals that have seen you for this condition.

_____
_____

Have you ever injured this part of your body or experienced this illness before?
___ yes ___ no if yes, give details.

_____
_____

Were there any witnesses to your accident? ___ yes ___ no If YES, please list their names. _____

I certify that the above statements are true to the best of my knowledge.

_____ _____
Employee Signature **Date**

_____ _____
Supervisor Signature **Date**