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**