PASADENA CITY COLLEGE
Risk Management Services

EMPLOYEE STATEMENT OF INJURY

EMPLOYEE NAME: _____ JOB TITLE: _____

HOME ADDRESS: _____ DEPARTMENT: _____

_____ PHONE NUMBER: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

TIME YOU BEGAN WORK_____ ☐ AM ☐ PM HOURS WORKED DAILY: _____

WORK DAYS: _____ TIME OF INJURY: _____ ☐ AM ☐ PM

DATE OF INJURY: _____ DATE REPORTED: _____

LOCATION WHERE INJURY OCCURRED: _____

PLEASE STATE SPECIFIC BODY PART (LEFT ARM, RIGHT FOOT, ETC.) AFFECTED AND TYPE OF INJURY:

_____

PLEASE STATE EQUIPMENT, MATERIALS AND/OR CHEMICALS BEING USED WHEN INJURY OCCURRED:

_____

DESCRIBE EVENTS THAT LED TO THE INJURY:

_____

_____

_____

WAS ANYONE ELSE INJURED? ☐ NO ☐ YES IF YES, NAME AND CONTACT INFORMATION:

_____

WHO DID YOU NOTIFY REGARDING THIS INJURY? _____

PLEASE NAME ANY WITNESSES: _____

_____

SIGNATURE _____ DATE _____