Employee statement regarding injury/illness/incident

Instructions: This form is for the collection and reporting of data associated with a reported work-related injury, illness, or incident. Supervisors should have employees reporting a work-related injury, illness, or incident immediately complete this form (electronic document is preferred method, paper copy is acceptable). This completed document along with all other required injury, illness, or incident forms should be sent to the Agency Workers' Compensation Coordinator within 24 hours of receiving notice of the injury, illness, or incident.

1. First name:	2. Middle initial:	3. Last name:

4. Emp/State ID #:	5. Work phone: ( )	6. Home phone: ( )	7. Date of incident:	8. Time of incident: ☐ am ☐ pm

9. Where did the incident occur? *(Please be specific, indicate building, floor, location, street address, etc. Draw a map if necessary)*

10. What were you doing when the incident occurred? *(Please indicate task being performed and include the activities immediately before incident)*

11. Give a detailed description of how the injury/illness occurred. *(Please include details about the work environment and any items being used)*

12. Describe the injury/illness and body part(s) affected. *(Please be specific, for example: I burned the tip of my index finger on the right hand.)*

13. Who was present when the injury/illness occurred? *(Please include the full names of anyone present)*

14. What changes do you suggest to prevent this from happening again?

15. Employee Signature: *(if submitting electronically, please type name)*	16. Date:

Insurer: Minnesota Dept. of Administration,
Risk Management Division, Workers' Compensation Program
P.O. Box 64081, St. Paul, MN 55164-0081
Phone (651) 201-3000

For office use:

Claimant Name_____ Date of Incident: _____

WC Claim #:_____SEMA4 Incident #:_____

WC Claim Specialist_____