Catoosa County Government

Workers' Compensation

Employee's Statement of Injury

Name:_____ Date of Birth:_____

Home Address:_____

_____

Phone Number:_____

Social Security Number:_____

Department:_____

Job Title:_____

Name of Your Supervisor:_____

Describe Your Job:

_____

_____

_____

Date of Accident:_____

Time of Accident:_____AM/PM

Place of Accident:_____

How did the accident happen?

_____

_____

_____

_____

Name and Phone Numbers of Witnesses, if any:

Describe your injury:

Did you ever injure this part of your body before?_____Yes _____No
If yes, when and where?

Signature:_____

Date:_____

Signature of Supervisor:_____

Date:_____