DEPARTMENT OF ADMINISTRATION

Risk Management Division
Workers' Compensation Program
50 Sherburne Avenue, Suite 309
Saint Paul, MN 55115
(651) 201-3000
FAX 651-297-5471

Employee injury/illness/incident statement

Instructions

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

Do not email directly from the website. Save a completed form to your computer, then email.

Identifying Questions

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 or PM

Investigative Questions

9. Where did the incident occur? (Please be specific. i.e. building, proximity to key structures, draw a map)

10. What were you doing when the incident occurred? (Please include the tasks being performed and include tasks immediately before the injury/illness/incident)

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

12. Describe the injury/illness/incident and body part(s) affected. (Please be specific. i.e. I burned the tip of my index finger on the right hand)

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

14. What changes do you suggest for preventing this from happening again?

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

For Office Use

Claimant Name:	Date of Incident:
WC Claim #:	
WC Claim Specialist:	