SANTA PAULA UNIFIED SCHOOL DISTRICT

EMPLOYEE STATEMENT

Name of injured Employee		Job Title
Department Name		Supervisor
Date of Injury, Illness, or Exposure	Time of Injury, Illness, or Exposure	Time work begins
Names of witnesses		

Type of injury, illness, or incident and <u>all</u> parts of body affected
(cut, strain, fracture, rash, etc. to right index finger, low back, left wrist, etc.)

Equipment, materials, and/or chemicals you were using when the injury, illness, or event occurred.

Specific activity you were performing when the injury, illness, or event occurred.

Were you performing regular job duties at the time of the injury, illness, or event occurred?
(If not, please explain)

How did the injury, illness, or event occur?
(Please describe fully the events that resulted in the injury, illness, or event. Use **Continuation Sheet** if necessary)

Have you previously injured this part(s) of your body before this injury or illness occurred, or did anything else affect your performance? (Please be specific)

How do you feel now?

_____ I would like to be examined by a doctor at this time
_____ I would not like to be examined by a doctor at this time **(Must complete attached Refusal of Medical Examination and/or Treatment Form).**

I certify that this is an accurate statement in my own words, which describes my injury, illness or incident and events leading to such result

Signature	Date
Home Address	Telephone Number

Please return this form to your supervisor when completed

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Continuation Sheet