

# EMPLOYEE STATEMENT OF INJURY

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYEE  
Fax or Email this completed form to FAS (972) 930-9479 or CLAIMS@FASTPA.COM

## EMPLOYER INFORMATION:

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_ City \_\_\_\_\_ State TX Zip \_\_\_\_\_  
PHONE \_\_\_\_\_ FAX \_\_\_\_\_ Policy# \_\_\_\_\_

## EMPLOYEE INFORMATION:

NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

GENDER  MALE  FEMALE PREFERRED LANGUAGE  ENGLISH  SPANISH

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS WHERE YOU WERE INJURED \_\_\_\_\_ YOUR JOB \_\_\_\_\_

DATE OF \_\_\_\_\_ TIME OF \_\_\_\_\_ DAY OF \_\_\_\_\_ TIME WORKSHIFT \_\_\_\_\_

INCIDENT \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ INCIDENT \_\_\_\_\_ A.M. \_\_\_\_\_ P.M. WEEK \_\_\_\_\_ STARTED \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

DATE INJURY REPORTED TO MANAGER \_\_\_\_\_ TIME REPORTED \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

EXACT AREA WHERE INJURED \_\_\_\_\_

DESCRIBE EQUIPMENT INVOLVED (IF ANY) \_\_\_\_\_

DESCRIBE WHAT YOU WERE DOING AT TIME OF INCIDENT \_\_\_\_\_

DESCRIBE FULLY HOW THE INCIDENT OCCURRED \_\_\_\_\_

WAS A SAFETY DEVICE APPLICABLE?  YES  NO WAS IT USED?  YES  NO

DESCRIBE NATURE OF INJURY \_\_\_\_\_

BODY PART(S) INVOLVED \_\_\_\_\_

HAVE YOU HAD A SAME OR SIMILAR INJURY BEFORE?  YES  NO IF YES, GIVE DETAILS \_\_\_\_\_

## WITNESSES -

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

Fellow Employee?  Yes  NO

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

Fellow Employee?  Yes  NO

I, \_\_\_\_\_ (Employee), the undersigned herewith CERTIFY that the foregoing statements and answers on this form are complete and true, and that no information has been omitted, and that I made such statements and answers of my own free will. I understand that my Employer does not carry Workers' Compensation insurance, and furthermore, that any payments to me or anyone else for expenses in connection with this incident and resulting in injury is not an admission of liability on the part of my Employer.

I authorize direct payment to medical providers and others rendering services in connection with this claim.

Employee Signature \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

Translated by (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

**Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.**