

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:

ADDRESS: _____ City: _____ State TX Zip: _____
PHONE: (_____) _____ FAX: (_____) _____ Policy# _____

EMPLOYEE INFORMATION:

NAME _____ D.O.B. ____ / ____ / ____ SOCIAL SECURITY NO. _____
HOME ADDRESS _____
CITY _____ STATE _____ ZIP _____ PHONE (_____) _____
OF DEPENDENTS (IF ANY) _____ MARITAL STATUS _____ GENDER MALE FEMALE
PREFERRED LANGUAGE IF OTHER THAN ENGLISH _____

INJURY INFORMATION

DATE OF INCIDENT ____ / ____ / ____ TIME OF INCIDENT ____ DAY OF WEEK ____ TIME WORKSHIFT ____
INCIDENT ____ / ____ / ____ INCIDENT ____ A.M. P.M. WEEK ____ STARTED ____ A.M. P.M.
DATE I REPORTED NJURY TO MANAGER ____ / ____ / ____ TIME REPORTED ____ A.M. P.M.

ADDRESS WHERE INJURY OCCURED _____ CITY _____
STATE _____ ZIP _____ PHONE (_____) _____ FAX (_____) _____

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 IF YES INDICATE THE DEVICE APPLICABLE _____

DESCRIBE NATURE OF INJURY _____

BODY PART(S) INVOLVED _____

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

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.