PROPERTIES AND FACILITIES DEPARTMENT
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STATEMENT OF PERSON INJURED OR WITNESSING AN INJURY AT WORKPLACE

This can also include persons who witness an injury, hazard or incident occurring.

A) FILL IN THE FOLLOWING INFORMATION ABOUT YOURSELF

NAME	
DATE OF BIRTH	
OCCUPATION	
WORKPLACE	
DATE STATEMENT GIVEN	

B) INJURY / HAZARD / INCIDENT INFORMATION

DATE IT OCCURRED	
LOCATION **WHERE** IT OCCURRED	
TIME **WHEN** IT OCCURRED	
DESCRIBE IN YOUR OWN WORDS IN THE SPACE BELOW OF WHAT CAUSED THIS INJURY. *If you need more space you may use the empty space of this page on its back.*	

C) FIRST AID PROVISION & MEDICAL ATTENTION FOR INJURY AT WORKPLACE

DID YOU SEEK FIRST AID ATTENTION	YES NO
NAME OF FIRST AIDER IN YOUR WORKPLACE	
WERE YOU TAKEN TO USP HEALTH & WELLNESS CENTER FOR TREATMENT	YES NO
DID YOU RETURN TO WORK AFTER THE INJURY	YES NO
WERE YOU GIVEN SICK LEAVE FROM THE DOCTOR	YES NO
HOW MANY DAYS OF SICK LEAVE WAS GIVEN TO YOU BY THE DOCTOR	

D) REPORTING TO SUPERVISOR

DID YOU OR YOUR WORKMATES INFORM YOUR SUPERVISOR OF THE INJURY?	YES NO
DID YOUR SUPERVISOR OR HIS DELEGATE OFFER YOU ANY ASSISTANCE FOR YOUR INJURY?	YES NO
DID YOUR SUPERVISOR ACCOMPANY YOU TO THE USP HEALTH AND WELLNESS CENTER FOR TREATMENT?	YES NO
NAME OF YOUR SUPERVISOR	
PHONE CONTACT OF YOUR SUPERVISOR	

E) PREVIOUS INJURY OR ILLNESS

HAVE YOU BEEN INJURED BEFORE	YES NO
DO YOU HAVE ANY PREEXISTING MEDICAL CONDITIONS	YES NO
IF YES WHAT ARE THESE CONDITIONS	

F) WITNESSES

Name Persons Who witnessed you sustain this injury	