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NORTHWESTERN
UNIVERSITY

Workers' Compensation Employee Accident Statement Form

Name _____

Date _____ Birthdate _____

Occupation _____ Supervisor _____

Accident Date _____ Accident Time _____

Accident Location _____

Injuries Sustained _____

Date Reported _____ Reported to Whom _____

Duties being performed when accident occurred _____

Witnesses _____

Detailed Accident Description _____

Employee Signature _____

All University employees who sustain work related injuries are required to complete the Workers' Compensation Accident Statement Form in its entirety. Completed forms should be mailed or faxed to the Office of Risk Management. See above.