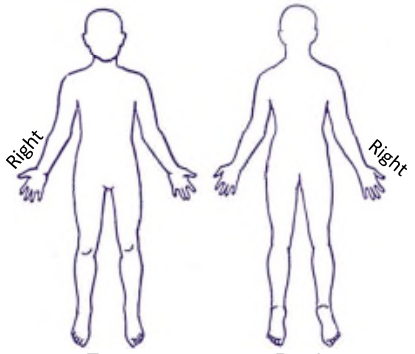
Employee Statement
FRM-HS-144.1

Name:					
Address:					
City:		State:		Zip:	
Home Phone:		Cell Phone:			

I hereby freely and voluntarily make the following statement.

Date of Incident:		
Location Of Incident:		
What were you doing prior to the incident?	☐ **Work** ☐ **Break** ☐ **Meal**	☐ **Entering or Traveling To Work Site** ☐ **Leaving or Traveling From Work Site** ☐ **Other:** _____
Describe, in detail, how the incident occurred:	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	
What was the result of the incident? **Injury:** What physically happened? **Vehicle:** What damage occurred? **Property Damage:** Describe damage to MPW and customer property	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	If this incident resulted in an injury, please indicate below what part of the body sustained an injury.  Front Back
Were there witnesses to the incident?	☐ **Yes** ☐ **No**	If yes, Witness name: _____ _____

Authorization for Release of Medical Information

Name of Clinic or Hospital:	
Address of Clinic or Hospital (Including City and State):	
Physician Name (if known):	
Please let any previous work-related injuries:	
Last Four (4) digits of Social Security Number:	

By signing this document I hereby permit the release of medical information, records and reports relative to the necessary administration of my Worker's Compensation claim to the appropriate state Bureau of Worker's Compensation, the employer or their representative, third party administrator (TPA) or authorized representatives. This release will expire upon the statutory expiration or settlement of this claim. A photocopy of this release is as valid as the original.

Printed Full Name		
First:	**Middle:**	**Last:**

Employee Signature Date

Please upload this completed form to the related incident in Intelex or fax to: 614-474-1702.