NORTH CAROLINA STATE GOVERNMENT WORKERS' COMPENSATION PROGRAM
EMPLOYEE STATEMENT AND LEAVE OPTIONS

You will need Adobe Acrobat full version in order to save the data in the fill-in fields.

Supervisors should provide all injured employees with this form to complete the information concerning the accident/incident and use of leave options for any time lost from work that may result from injury. This Form should be completed in detail to give an accurate account of the case. Once the employee completes form, supervisor completes bottom portion and submits to agency WC Administrator.

EMPLOYEE STATEMENT

Employee Information

Employee Name: _____ SS#: _____

Banner ID: _____ Immediate Supervisor: _____

Department: _____

Division/Unit: _____

Injury Information

Date of Injury: _____ Time of Injury: _____

Date Injury Reported: _____ Reported To: _____

Location: _____ County: _____

Part(s) and side of Body Injured: _____

Description and Cause of Accident (be detailed in your explanation – EXAMPLE: fall, scrape, falling object, etc.)

I understand the information above will be used by my employer to help determine liability for the injury. I acknowledge that the above statement is a true and accurate representation of this information.

_____ _____

Employee Signature **Date**