KEYSTONE®

"EMPLOYEE" - STATEMENT OF INJURY OR ILLNESS

EMPLOYEE INFORMATION [To be completed by Employee]		
Name (First, Last)	Date of Birth	Social Security Number
Address: (Street, City, State, Zip)		
Phone Number(s): Home: Other:		
Job Title:	Department:	Shift:
Did the injury occur on the employer premises? ☐Yes ☐ No If No, Where?	LOCATION:	

Date of Accident	Normal Shift Start Time	Time of Accident	Worked Until End of Shift
	☐AM ☐ PM	☐AM ☐PM	☐YES ☐ NO
Accident was reported to:			

Description of Injury (Describe how the injury occurred, be specific)

Part (s) of Body Injured: (check all that apply)

☐ **Arm**	☐ **Face**	☐ **Groin**	☐ **Internal Organs**	☐ **Neck**	☐ **Wrist**
☐ **Back**	☐ **Finger**	☐ **Hand**	☐ **Leg**	☐ **Elbow**	☐ **Shoulder**
☐ **Eye**	☐ **Foot/feet**	☐ **Head**	☐ **Knee**	☐ **Stomach**	☐ **Other (describe)**

Please describe the injured Body Part(s) [i.e. left foot, right thumb]:

I hereby declare that the statements provided in this document are; to the best of my knowledge and belief, complete and true. Fraud Notice: Any Individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act165.

Employee Signature: **Date:**
Original Signature Required.