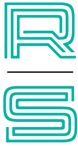

RETAIL
ASSOCIATION
SERVICES Inc.

SWORN STATEMENT OF INCIDENT REPORT

Employer Name
Account I.D.

***** FOR SUPERVISOR'S COMPLETION IN EMPLOYEE PRESENCE *****

NAME	SSN
ADDRESS	DATE OF BIRTH
CITY, STATE & ZIP	TELEPHONE #
POSITION	DATE OF HIRE
DATE OF INJURY	TIME OF INJURY A.M./P.M.
NATURE OF INJURY	PART OF BODY

ACCIDENT DESCRIPTION:

____

____

____

____

WITNESSES:

PHYSICIAN'S NAME	ADDRESS & PHONE NUMBER
PREVIOUS PHYSICIAN SEEN	ADDRESS & PHONE NUMBER
PREVIOUS PHYSICIAN SEEN	ADDRESS & PHONE NUMBER

Will you lose time from work? ______ Last date worked? ___________ Date returned? _____________

Was injury by unsafe act or condition? If yes, explain:

What could be done to correct this?

Previous injuries or illnesses?

I have read the above answers and my responses are true and correct to the best of my knowledge.

EMPLOYEE SIGNATURE	DATE