RETAIL ASSOCIATION SERVICES Inc.

Sworn Statement of Incident Report

EMPLOYER'S NAME | SUVERVISOR'S NAME

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

NAME

ADDRESS | DATE OF BIRTH

CITY, STATE, ZIP | TELEPHONE #

POSITION | DATE OF HIRE

DATE OF INJURY | TIME OF INJURY PM

NATURE OF INJURY | PART OF BODY

ACCIDENT DESCRIPTION:

WITNESSES

PHYSICIAN'S NAME | ADDRESS & PHONE NUMBER

PREVIOUS PROVIDER SEEN | ADDRESS & PHONE NUMBER

PREVIOUS PROVIDER SEEN | ADDRESS & PHONE NUMBER

Will you lose time from work? Yes Last Date worked? _____ Date returned? _____

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

What could be done to correct this?

Previous injuries or illnesses?

The above answers and responses are true and correct to the best of my knowledge.

EMPLOYEE'S SIGNATURE	DATE
SUPERVISOR'S SIGNATURE	DATE

To send this form to RS, save it to your computer and email to: admin@waretailservices.com