Employee statement regarding injury/illness/incident

Instructions: This form is for the collection and reporting of data associated with a reported work-related injury, illness, or incident. Supervisors should have employees reporting a work-related injury, illness, or incident immediately complete this form (electronic document is preferred method, paper copy is acceptable). This completed document along with all other required injury, illness, or incident forms should be sent to the Agency Workers' Compensation Coordinator within 24 hours of receiving notice of the injury, illness, or incident.

1. First name:	2. Middle initial:	3. Last name:

4. Emp/State ID #:	5. Work phone: ( )	6. Home phone: ( )	7. Date of incident:	8. Time of incident: ☐ am ☐ pm

9. Where did the incident occur?

Insurer: Minnesota Dept. of Administration,
Risk Management Division, Workers' Compensation Program
P.O. Box 64081, St. Paul, MN 55164-0081
Phone (651) 201-3000

For office use:

Claimant Name_____ Date of Incident: _____

WC Claim #:_____SEMA4 Incident #:_____

WC Claim Specialist_____