

**CACHE COUNTY SCHOOL DISTRICT  
EMPLOYEE INJURY STATEMENT FORM**

To be Completed by Injured Employee and Sent to District Office

Employee's Name: \_\_\_\_\_ SS# \_\_\_\_\_

School or Program where employed: \_\_\_\_\_

Date of injury: \_\_\_\_\_ Time of injury: \_\_\_\_\_

Location where injured: \_\_\_\_\_  
(Example: District Office hallway)

Did you get medical treatment? \_\_\_\_\_ If yes, what treatment? \_\_\_\_\_

Did you miss any work? \_\_\_\_\_ Did you go to WorkMed? \_\_\_\_\_

If not, where were you treated? \_\_\_\_\_

What job duties were you performing when this injury occurred? \_\_\_\_\_

Explain in your own words what happened and describe your injury. Please note if it was **right** or **left** side, where applicable. Please write clearly.

I certify that my statement in this report is true, correct, and complete to the best of my knowledge.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

*Please submit this form to the District Office no later than **two (2)** working days after the injury was incurred.*