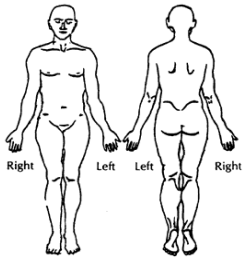
Accident Report
Employee's Statement

State Employee Injury Compensation Trust Fund/SEICTF

This form is to be completed by the employee and submitted to the immediate supervisor on the day the injury occurs. The supervisor should submit the First Report of Injury (SEICTF Form 1) along with this completed form immediately to 334-223-6170 or 888-827-6753.

Date of Injury/Accident	Today's Date	: (circle one) a.m. / p.m. Time of Injury/Accident
Employee Name (Last, first, middle initial)	/ / Date of Birth	- - Social Security Number
Street address		City State Zip Code
Primary phone number	Email address	
Preferred method of contact by SEICTF: (choose one) ☐ Email ☐ US Postal Service Mail Delivery		
Job Title/Classification	Name of Supervisor	Date Supervisor Notified



Circle Injured Body Part

Describe the specific activity you were performing at the time the injury/accident occurred including exactly what happened to cause injury/accident.

Accident:_____

_____

Injuries/Body Part(s): _____

_____

Exact location where injury/accident occurred: _____

_____

Were there any witnesses? ☐ Yes ☐ No — If so, give names, addresses and phone numbers of each:

_____

_____

Was injury/accident a result of an automobile accident? ☐ Yes ☐ No

If yes, obtain a copy of the police report of accident and submit to supervisor as soon as possible.

At the time of the injury/accident, were you using any protective equipment (ex. Latex gloves, eye protection)? ☐ Yes ☐ No

If yes, list equipment used. _____

Have you had previous treatment or injury to the same body part(s)? ☐ Yes ☐ No

If yes, enter body part affected, date(s) of injuries and name(s) and address(es) of treatment provider(s).

_____

_____

I understand the intentional reporting of false information will disqualify me from receiving further SEICTF benefits and could expose me to penalties or criminal charges. I certify the information is correct to the best of my knowledge.

I further understand that non-compliance with SEICTF Rules (i.e. failure to attend medical appointments as scheduled, failure to respond to requests for contact, failure to provide signed medical authorization forms, failure to comply with your physician's medical treatment plan, etc.) will progressively lead to suspension and/or termination, per Administrative Procedures Act 355-8-1.03(e).

_____ Signature of Employee		_____ Date
_____ Signature of Supervisor reporting incident	_____ Date	_____ Daytime Phone