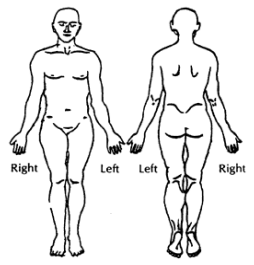




# ACCIDENT REPORT EMPLOYEE'S STATEMENT

State Employee Injury Compensation Trust Fund  
SEICTF

This form must 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 [SEICTF@finance.alabama.gov](mailto:SEICTF@finance.alabama.gov) or via fax to 334-223-6170 or 888-827-6753.

<hr/> Date of Injury/Accident	<hr/> Today's Date	(circle one) a.m. / p.m.
<hr/> Employee Name (Last, first, middle initial)	<hr/> Date of Birth	Time of Injury/Accident On break or at lunch at the time of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No
<hr/> Street address		<hr/> Social Security Number (Complete SSN not just last four.)
<hr/> Primary phone number		<hr/> City State Zip Code
<hr/> Email address		
Preferred method of contact by SEICTF: (choose one) <input type="checkbox"/> Email <input type="checkbox"/> US Postal Service Mail Delivery		
<hr/> Job Title/Classification Code	<hr/> Name of Supervisor	<hr/> Date Supervisor Notified
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:		 <p>Circle Injured Body Part</p>
Were there any witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, give names, addresses, and phone numbers of each:
Was injury/accident a result of an automobile accident?		<input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list equipment used:		
Have you previously had pain, treatment, diagnostic testing (x-rays, MRI, etc.) or injury to the same body part(s)?		<input type="checkbox"/> Yes <input type="checkbox"/> 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 all 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 cooperate with SEICTF staff, 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).		
<hr/> Signature of Employee		<hr/> Date
<hr/> Signature of Supervisor reporting incident	<hr/> Date	<hr/> Daytime Phone