

Not Injured/Witnessed an Injury Form

**INSURED SOLUTIONS
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Atlanta, GA 30346
877-213-1999**

EMPLOYEE INJURY STATEMENT LIST

This page covers the time period from _____ to _____.

Sign and date below and indicate by checking the appropriate box(es) whether or not you were injured in a work-related accident and whether or not you witnessed a work-related accident during the course of your employment during the timeframe indicated above. Also, check the appropriate box to indicate that you have reported any accidents or injuries to your designated supervisor.

Date	Signature	Not Injured	Did Not Witness	Was Injured	Did Witness	Supervisor Notified
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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