Employee Confirmation of Work Related Injury

Employee Name: _____ Injured at: _____
(Please Print) (Location or Terminal Name)

I was injured on _____, at _____ am / pm.
(Date)

At the time I was injured, I was performing the following work: _____

_____

_____

_____

_____

The injury occurred when (explain briefly): _____

_____

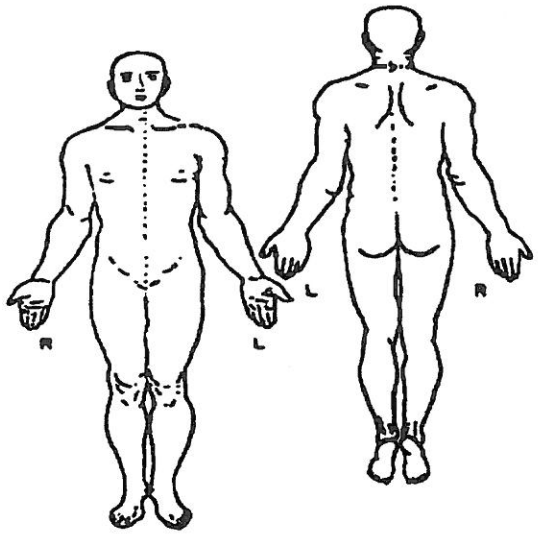
_____

Indicate the part(s) of the body injured (Be specific - e.g., front left shin, right wrist, etc.):

_____

_____

Please place an X on the injured part(s) of the body.



On-duty Supervisor at the time of injury:

_____

Name of Witnesses:

_____

_____

_____

_____

RELEASE AUTHORIZATION FOR WORKERS COMPENSATION INJURY MEDICAL RECORDS AND COMMUNICATION

I hereby authorize any, medical provider, hospital, clinic or other medically related facility, insurance company or other organization, institution, or person, that has any records or knowledge of my medical history, condition or well-being, to supply and communicate, orally or in writing, such information to my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys; including information as to my care and treatment and as to my work injury or duties and ability to work. In conjunction with this, I also authorize any treating physician or medical provider to review any additional medical records provided to them. A facsimile, e-mail or other electronic copy of this authorization shall be valid as the original. This release shall remain valid for the length of my claim.

_____ _____ _____
Signature Social Security # Date