

NO INJURY CERTIFICATE

Employer: _____

Location/Department: _____

(Initial and complete as appropriate)

___ I have not suffered any injury during my employment period _____ (date) through _____ (date).

___ I suffered an injury to my _____ (part of body) on _____ (date) during my employment, which was (___) was not (___) reported to my supervisor _____ (name).

I have (___) or have not (___) witnessed an accident resulting in injury to someone else.

IMPORTANT NOTICE: THIS REPORT IS FOR INJURY REPORTING PURPOSES ONLY. BY FLORIDA LAW AN EMPLOYER MUST PAY WAGES EARNED BY AN EMPLOYEE WITHOUT IMPOSING ANY CONDITIONS SUCH AS SIGNING THIS FORM. NO EMPLOYEE WILL BE REQUIRED TO FILL OUT THIS FORM IN ORDER TO RECEIVE HIS OR HER WAGES.

I certify that I have signed this form freely and voluntarily for reporting purposes only.

Employee Signature

Date