**ACCIDENT INVESTIGATION REPORT**

***Immediate completion of this form will help us to assist employees in obtaining workers’ compensation benefits and help us prevent injuries to others.***

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| Insured:       | Today’s Date:       |
| Department:       | Time:       |

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| Part 1 **EMPLOYEE MUST COMPLETE AND ANSWER ALL QUESTIONS**  |
| First Name      | M.I.      | Last Name      | Your Usual Occupation      | Date of Birth      |
| Home Address (Number and Street)      | City      | State      | Zip      |
| Home Phone #(      )       | Sex[ ]  Male [ ]  Female | Marital Status      | Length of Time Employed      |
| Date and Time of Accident       [ ]  AM [ ]  PM | Exact Location Where Accident Occurred      |
| Occupation at Time of Accident      | On Employer’s Premises?[ ]  Yes [ ]  No |
| Employee’s Complete Description of Accident (Give details in explaining what happened.)      |
|       |
|       |
| Description of Injury (Give details including part of body injured.)      |
|       |
| Did anyone witness this accident? [ ]  Yes [ ]  NoWitness Name(s):       |
| Employee’s Signature | Social Security #      |

**SHOULD BE COMPLETED BY EMPLOYEE’S DIRECT SUPERVISOR**

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| Part 2 **TO BE COMPLETED BY SUPERVISOR TO WHOM ACCIDENT REPORTED – REPORT ALL HAZARDS IMMEDIATELY!** |

Supervisor’s name and title:

1. Do you usually supervise this individual? [ ]  Yes [ ]  No For how long?

2. Was accident immediately reported? [ ]  Yes [ ]  No\* (Explain below) (If no, when and how did you learn of the accident?)

3. Was employee working [ ]  alone\* (Explain below) [ ]  with crew or fellow workers?

4. Was employee at work on company time? [ ]  Yes [ ]  No\* (Explain below)

5. Did you physically inspect the area where injury occurred? [ ]  Yes [ ]  No\* (Explain below)

6. Any unsafe conditions or unusual hazards present? [ ]  Yes\* [ ]  No

7. Evidence of horseplay? [ ]  Yes\* [ ]  No

8. Evidence of intoxication? [ ]  Yes\* [ ]  No

9. Evidence of drug use? [ ]  Yes\* [ ]  No

10. Was employer provided safety equipment in use? [ ]  Yes [ ]  No\*

11. Was immediate medical attention necessary? [ ]  Yes [ ]  No If yes, where?

 If yes, where?

 By whom?

12. Is employee at work now? [ ]  Yes [ ]  No

 If no, when do you expect employee to return?

13. Are you satisfied that the accident/injury occurred as described above? [ ]  Yes [ ]  No\*

14. Do you feel that accidents such as this can be avoided in the future? [ ]  Yes\* [ ]  No

15. Describe action(s) taken to prevent recurrence: (safety talk with employees, eliminate unsafe practice, remove hazards, etc.)

16. Do you want to discuss this matter with the Claim Representative? [ ]  Yes\* [ ]  No

17. Was employee wearing back support? [ ]  Yes [ ]  No\*

**Explain all \* items by number**

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| Prepared by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature | Department:      | Date:      |