**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.***

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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  No  Witness Name(s): | | | | | | | | | | | | |
| Employee’s Signature | | | | | | | Social Security # | | | | | |

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

|  |
| --- |
| 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**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

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