WORKERS COMPENSATION - INVESTIGATION OF ACCIDENT

PCA WC # | **PCA INCIDENT/CLAIMS #**

EMPLOYEE INFORMATION

Name
Street Address
City/State/Zip Code
Social Security No. | Date of Birth
Home Phone No. | Age
Marital Status | Number of Dependents
☐ MALE ☐ FEMALE
City and facility/lot where regularly employed:
Date of Hire
Was employee required to miss any work? ☐ YES ☐ NO | If yes, date employee returned:
Was employee paid for the day of injury? ☐ YES ☐ NO | Wage Rate
How long has employee worked on the job at location of incident?
Average hour worked per day: | Average days per week:
Employee's usual days off work:

ACCIDENT INFORMATION

LOCATION
Injury Date | Was the accident on employer's premises? ☐ YES ☐ NO
Location where accident occurred
Time of Injury | Time Shift Began
Date employer was notified | Who was notified?

DESCRIPTION OF INJURY

What part of the body was injured? (Be SPECIFIC: i.e., right index finger, right upper arm, lower back, left knee, etc.)

What was the nature of injury? (i.e., burn, fracture, strain, etc.)
Describe what happened. Be SPECIFIC

What was the employee doing immediately preceding the incident?

Are you aware of any handicap this employee had prior to the injury? ☐ YES ☐ NO
If yes, describe:
Was any property damaged? ☐ YES ☐ NO
If yes, describe:
Was safety equipment provided? ☐ YES ☐ NO | Was it used? ☐ YES ☐ NO

NUMBER OF WITNESSES:	
WITNESS NO. 1	
Witness Name	
Address	
City/State/Zip Code	
Home Phone #	
Business Phone #	
WITNESS NO. 2	
Witness Name	
Address	
City/State/Zip Code	
Home Phone #	
Business Phone #	

TREATMENT

Employee Name:

Employee went to (check one): ☐ CLINIC ☐ HOSPITAL ☐ EMERGENCY ROOM ☐ FIRST AID ☐ URGENT CARE

Describe any first-aid administered; state by whom:

Name and Address of Clinic, Hospital, Emergency Room or Urgent Care:

Name, Address & Phone No. of Treating Physician:

Was employee sent to take a drug test? ☐ YES ☐ NO *If no, Manager needs to forward a separate explanation to the insurance Department to document reason no test was ordered.

Name of drug testing facility:

Were notices and posted doctor panels explained to employee and supporting document signed? ☐ YES ☐ NO

CAUSE

Please indicate the cause of the illness or incident:

Was a policy in effect regarding cause? ☐ YES ☐ NO

What was the policy in effect? (Either describe or attach a copy of the policy)

Was employee aware of the policy? ☐ YES ☐ NO

How was employee notified of the policy?

EMPLOYEE'S COMMENTS*
*This section must be completed
Employee's Signature _____ Date _____
SUPERVISOR'S COMMENTS*
*This section must be completed
Supervisor's Signature _____ Date _____