

WORKERS' COMPENSATION . INVESTIGATION OF ACCIDENT

Each incident, whether serious or minor, should be investigated to prevent recurrence. The real causes can be determined and corrected only after thorough investigation which may include interviews with the injured and witness and visit to the scene of the incident. Attach additional sheets if necessary for more information.

		I=IVII	PLOYEE INFORMAT	ION			
Name:							
Address:							
Social Security No.			Date of Birth		Age		
Home Phone No.			Marital Status		No. of Dependents		
Male	Female						
City and lot or facility where regularly employed:							
Date of Hire:			Occupation (at time of Incident):				
Was employee requir	as employee required to miss any work? YES			If yes, date employe	e returned to work:		
Was employee paid for the day of injury? YES			NO	Wage Rate:	\$		
How long has employee worked on the job at which the incident occurred?							
Average hours worked each day:		Average days per week:		Employee's usual days off work:			
ACCIDENT INFORMATION							
Injury Date:		Was the accident on the employer's premises? YES NO					
Location where accid	lent occurred:						
Time of Injury:		AM/PM (circle)	Time Shift Began:		AM/PM (circle)		
Date employer was n	otified of injury:		Who was notified?				
DESCRIPTION OF INJURY							
What part of body was injured (BE SPECIFIC: i.e. right index finger, right upper arm, lower back, left knee, etc.):							
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What was nature of injury (i.e. burn, fracture, strain):							
Describe what happened(BE SPECIFIC):							
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What was employee doing immediately preceding incident?							
Are you aware of any handicap this employee had prior to the injury? YES NO							
If yes, describe:							
Was any property dai	maged? YES	NO NO	If yes, describe:				
Was safety equipmer	nt provided? YES	NO	Was it used?	YES NO			
Witnesses (List Name, Address, Home & Business Phone for each):							
1)							
- /							
2)							
2)							
3)	3)						

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Employee Name: Date: **TREATMENT** Employee went to (circle one:) Clinic Hospital **Emergency Room** First-Aid Describe any first-aid administered; state by whom administered: Name and Address of Clinic, Hospital or Emergency Room: Name, Address and Phone No. of Treating Physician: Was employee sent to take a drug test? YES *If no, Manager needs to forward a separate explanation to the Insurance Department to document reason no test was ordered. NO Name of drug testing facility: Were notices and posted doctor panels explained to employee and supporting documents signed? YES NO **CAUSE** Please indicate which of the following contributed to the illness or incident: Improper Instruction Failure to look out Lack of training or skill Unsafe arrangement or process Unsafe position Poor ventilation Operating without authority Improper dress Horseplay Physical or mental impairment Unsafe equipment Improper maintenance Improper protective equipment Poor housekeeping Improper guarding Failure to secure area Inoperative safety device Other: YES Was a policy in effect? NO What was policy in effect ? (either describe or attach a copy of policy) YES Was employee aware of policy? NO How was employee notified of policy? **EMPLOYEE'S COMMENTS *** * This section MUST be completed. Employee's Signature Date: SUPERVISOR'S COMMENTS* (Attach conclusions from analysis on separate page) * This section MUST be completed. Supervisor's Signature Date: