



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.

EMPLOYEE INFORMATION

Name:					
Address:					
Social Security No.		Date of Birth		Age	
Home Phone No.		Marital Status		No. of Dependents	
Male <input type="checkbox"/> Female <input type="checkbox"/>					
City and lot or facility where regularly employed:					
Date of Hire:		Occupation (at time of Incident):			
Was employee required to miss any work?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, date employee returned to work: <input type="text"/>		
Was employee paid for the day of injury?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	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 <input type="checkbox"/> NO <input type="checkbox"/>			
Location where accident occurred:					
Time of Injury:		AM/PM (circle)	Time Shift Began:		AM/PM (circle)
Date employer was notified 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.):	
What was nature of injury (i.e. burn, fracture, strain):	
Describe what happened (BE SPECIFIC):	
What was employee doing immediately preceding incident?	
Are you aware of any handicap this employee had prior to the injury? YES <input type="checkbox"/> NO <input type="checkbox"/>	
If yes, describe: <input type="text"/>	
Was any property damaged? YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes, describe: <input type="text"/>
Was safety equipment provided? YES <input type="checkbox"/> NO <input type="checkbox"/>	Was it used? YES <input type="checkbox"/> NO <input type="checkbox"/>
Witnesses (List Name, Address, Home & Business Phone for each):	
1) <input type="text"/>	
2) <input type="text"/>	
3) <input type="text"/>	

