Accident investigation forms/statements should be filled out by the injured employee, supervisor or any witness to the accident.

Train your supervisors to conduct the preliminary investigation as soon as possible.

**IMPORTANT** - Care must be taken to assure the investigation is fact finding, not fault finding. Obtaining signed statements as soon as possible following an accident insures that you, the employer, have an accurate account of how the injury occurred. These completed statements are important in helping to correct hazards and prevent the accident from recurring. They also help to spot possible third-party liability as well as possible fraudulent claims.

**After I have these forms completed - what do I do with them?**

Hold on to them. When you call the COMPcall injury hotline to report the accident, advise the operator that these forms were completed or if you are planning to have the forms completed. Please keep the completed forms for future reference and inform the IWIF claims adjuster you have them if needed. These completed forms can be valuable information in the claims investigation of an injury and for building a case in the event of a workers comp hearing.

**What if my injured employee is physically unable to fill out the Employee’s Report of Injury?**

Use common sense and good judgement. If the injury is severe - remember, your employee’s health and care are first and foremost. If possible, have the form filled out at a later, more appropriate time when the employee is physically able to document the accident.

**What if my employee refuses to fill out or sign an Employee’s Report of Injury?**

Of course, you cannot make an employee fill out the document. You can however stress the importance of getting “their” account of the accident to help prevent the injury from happening again. Also, still obtain the supervisor’s report as well as any witness statements.

**What if my Employee has retained an attorney - Can I still ask the injured employee to fill out an Employee's Report of Injury?**

Yes - you, the employer as part of your company’s accident management plan, can still ask the employee to fill out the report form.
Employee’s name: __________________________________________________________ Male__ Female__

Date of birth: ____/____/____          Home Telephone # ( ______ )  _________________________________

Home Address: ___________________________________________________________________________

City: ______________________________________________ State: ______  Zip Code: _________________

Present classification: __________________________________ How long employed here: _____________

Social Security No.: _______-______-__________  Bi-weekly salary: ______________________________

Location of accident: ______________________________________________________________________

Name of building            Area (bathroom, etc.)

Date of accident: _________________________________________  Time of accident: __________________

Describe fully how accident occurred: ________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Describe bodily injury sustained (be specific about body part(s) affected):  ___________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Recommendation on how to prevent this accident from recurring:____________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Name of Supervisor: ______________________________________________________________________

Name(s) of Witness(es): ___________________________________________________________________

(Attach witness(es) report(s))

When did you report the accident to your supervisor? ____________________________________________

Signature of employee: _____________________________ Date: __________________
Injured Employee’s name: _____________________________________________

Name of Witness: ___________________________________________________

Job title of Witness: _________________________________________ How long employed here?________

Home address of witness: __________________________________________________________________

City: ______________________________________________ State: ______  Zip Code: _________________

Location of accident: ______________________________________________________________________

Date of accident: _________________________________________  Time of accident: __________________

Describe fully how accident occurred: ________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Describe bodily injury sustained (be specific about body part(s) affected):  ___________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Recommendation on how to prevent this accident from recurring:____________________________________

_______________________________________________________________________________________

Name of Supervisor: ______________________________________________________________________

Signature of Witness: ___________________________  Date: __________________
**Supervisor's Accident Investigation**

(To be completed by the employee's supervisor or other responsible administrative official)

<table>
<thead>
<tr>
<th>Location where accident occurred</th>
<th>Employer's Premises: Yes ☐ No ☐</th>
<th>Date of accident or illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who was injured?</td>
<td>Employee ☐ Non-Employee ☐</td>
<td>Time of accident a.m. ☐ p.m. ☐</td>
</tr>
<tr>
<td>Length of time with firm</td>
<td>Job title or occupation</td>
<td>Name of dept. normally assigned to</td>
</tr>
<tr>
<td>What property was damaged?</td>
<td>How long has employee worked at job where injury or illness occurred?</td>
<td></td>
</tr>
<tr>
<td>What was employee doing when injury/illness occurred?</td>
<td>What machine or tool?</td>
<td>What operation?</td>
</tr>
<tr>
<td>How did injury/illness occur?</td>
<td>List all objects and substances involved.</td>
<td></td>
</tr>
<tr>
<td>Part of body affected</td>
<td>Any prior physical defects? If so, what? Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>Nature and extent of injury/illness and property damaged (be specific)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS**

- Improper instruction
- Lack of training or skill
- Operating without authority
- Horseplay
- Physical or mental impairment
- Failure to secure
- Failure to lockout
- Unsafe position
- Improper dress
- Improper protective equipment
- Unsafe equipment
- Poor housekeeping
- Unsafe arrangement or process
- Poor ventilation
- Improper guarding
- Improper maintenance
- Inoperative safety device
- Other ____________________

Supervisor's corrective action to insure this type of accident does not reoccur: ______________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Was employee retrained in the appropriate use of Personal Protective Equipment/Proper safety procedures? Yes ☐ No ☐

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? Yes ☐ No ☐

Supervisor's name ___________________________ Supervisor's signature ___________________________ Date ________

Form may be copied as needed