Accident Investigation Forms

HOW TO USE THESE IMPORTANT TOOLS

Accident investigation forms/statements **should be filled out by the injured employee, supervisor and 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 ensures 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?

Please send the completed forms to your HRSP Risk Management Office and keep a copy for your files. These completed forms can provide valuable information in a claims investigation of an injury and for developing the defense in the event of a workers' comp hearing.

DOCUMENT INCLUDED:

- Employee's Report of Injury Form
- Accident Witness Statement Form
- Supervisor's Accident Investigation Form

WHAT IF MY INJURED EMPLOYEE IS PHYSICALLY UNABLE TO FILL OUT THE REPORT?

Use common sense and good judgment. 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 A REPORT?

Of course, you cannot make an employee fill out the document. You can, however, stress the importance of getting his or her account of the accident to set the record straight and to help prevent the accident from happening again. Also, still obtain the supervisor's report as well as any witness statements.

CAN I STILL ASK THE INJURED EMPLOYEE TO FILL OUT A REPORT IF THEY RETAIN AN ATTORNEY?

Yes. You, the employer, as part of your company's accident management plan, can still ask the employee to fill out the report form.

NEED HELP?

If you would like assistance in setting up supervisory training on how to use these forms, please contact your HRSP Risk Department or Safety Management Consultant at 210-756-5409

Employee's Report of Injury

Policy holder: _____

Policy #: _____

TO BE COMPLETED BY THE EMPLOYEE ONLY

Employee's name: _____
Last First Middle

Male _____ Female _____ Date of birth: ____/____/_____ Home Phone # _____

Marital status: M _____ D _____ W _____ S _____ Height/Weight: _____" /_____ lbs. Dominant Hand: _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Current job position: _____ Length of employment here: _____

Social Security #: _____-_____-_____ Weekly salary: _____

Location of accident: _____
Address and location of accident (loading dock, bathroom, etc.)

Date of accident: ____/____/_____ Time of accident: _____

Describe fully how accident occurred (including events that occurred immediately before the accident): _____

_____

_____

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

_____

_____

Recommendation on how to prevent this accident from recurring: _____

_____

Name of supervisor: _____ Phone # _____
Last First

Name(s) of witness(es): _____ Phone # _____
Attach witness(es) report(s)

To whom did you report the injury? _____

When did you report the accident? _____ Do you require medical attention? Yes ____ No ____ Maybe ____

Name of your treating physician: _____ Phone # _____

Signature of employee: _____ Date: _____
Note: form must be signed by hand

Form may be copied as needed.

Accident Witness Statement

Policy holder: _____

Policy #: _____

TO BE COMPLETED BY ACCIDENT WITNESS

Injured employee's name: _____
Last First Middle

Name of witness: _____ Home Phone # _____
Last First Middle

Job title of witness: _____ Length of employment here: _____

Any relation to the injured employee? Yes ____ No ____ If yes, what relation? _____

Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Location of accident: _____
Address and location of accident (loading dock, bathroom, etc.)

Date of accident: ____/____/_____ Time of accident: _____

Describe fully how accident occurred (including events that occurred immediately before the accident): _____

_____

_____

_____

_____

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

_____

_____

_____

Recommendation on how to prevent this accident from recurring: _____

_____

_____

Name of witness' supervisor: _____ Phone # _____
Last First

Signature of witness: _____ Date: _____
Note: form must be signed by hand

Form may be copied as needed.

Supervisor's Accident Investigation Form

Policy holder: _____

Policy #: _____

TO BE COMPLETED BY THE EMPLOYEE'S SUPERVISOR OR RESPONSIBLE ADMINISTRATIVE OFFICIAL

Date of accident: ___/___/_____ Time of accident: _____ Employer's Premises: Yes ___ No ___ Job site: Yes ___ No ___

Employee ___ Non-employee ___ If non-employee, specify_____

Location where accident occurred: _____ Who was injured? _____

Length of time with firm: _____ How long has employee worked at site where incident occurred?_____

Job title or occupation: _____ Name of dept. normally assigned to: _____

What property/equipment was damaged? _____ Owned by: _____

What was employee doing when injury/illness occurred? What machine or tool was being used? What type of operation? _____

_____

Part of body affected/injured? _____ Prior physical conditions? Yes ___ No ___ If so, what?_____

Nature and extent of injury/illness and property damaged (be specific):_____

How did injury/illness occur? List all objects and substances involved _____

_____

Was the accident the result of another party's negligence? Yes ___ No ___ If so, name the party: _____

Do you have any concerns about this alleged accident or injury? Yes ___ No ___ If so, please specify: _____

_____

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

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

Supervisor's corrective action to ensure this type of accident does not recur: _____

_____

_____

Was employee trained in the appropriate use of Personal Protective Equipment/proper safety procedures? .....Yes ___ No ___

Was employee using the appropriate Personal Protective Equipment/proper safety procedures at the time? .....Yes ___ No ___

Did employee promptly report the injury/illness?.....Yes ___ No ___

Is there modified duty available?.....Yes ___ No ___

Supervisor's name: _____ Phone # _____

Supervisor's signature: _____ Date: _____

Note: form must be signed by hand