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 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, which can help defend against the claim.

After I have these forms completed - what do I do with them? Please send the completed forms to your IWIF Claims Adjuster 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.

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 Report of Injury

(To be completed by the employee only.)

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.: _______-______-__________

Weekly salary: __________________________

Location of accident:______________________________________________________________________

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#_______________________

Name(s) of witness(es): _________________________________________

Phone#_______________________

When did you report the accident to your supervisor? __________________

To whom did you report the injury?____________________________________

Do you require medical attention? Yes:_______  No:_______  Maybe:__________

Name of your treating physician:________________________________

Phone#_______________________

Signature of employee: ________________________________________

Date: ______________________

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Form may be copied as needed
Injured employee's name: ___________________________________________

Name of witness: ________________________________________________ Ph# _______________

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: (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's Supervisor: ______________________________________ Ph#_________________

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:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job site:</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Date of accident or illness</td>
<td>a.m.</td>
<td>p.m.</td>
<td></td>
</tr>
</tbody>
</table>

Who was injured?  
- Employee  
- Non-Employee

Length of time with firm

Job title or occupation

Name of dept. normally assigned to

How long has employee worked at job where injury or illness occurred?

What property/equipment was damaged?

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

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

Part of body affected/injured?

Any prior physical conditions?  
- Yes  
- No

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

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

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

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 cautioned for failure to use Personal Protective Equipment/Proper safety procedures? .......... Yes ___ No ____
Did employee promptly report the injury/illness? ............................................................................... Yes ___ No ____
Is there modified duty available? .............................................................................................. Yes ___ No ____

Supervisor's name  

Supervisor's signature  

Phone#  

Date

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Form may be copied as needed