

Accident Investigation FORMS

How To Use These Important Tools

Includes:

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

Need Help?

If you would like assistance in setting up supervisory training on how to use these forms, or if you need additional copies please contact the IWIF Human Resources department at 410-494-2057.

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



IMPORTANT - Obtaining signed statements as soon as possible following an accident insures that the employer has an accurate account of how the injury occurred, helps correct hazards to prevent the accident from recurring, and assures the employees claim is documented.

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

Promptly submit your completed forms to the IWIF Human Resources department. The supervisor should also keep copies of the forms for future reference.

IWIF has retained SISCO as our independent claim adjusting firm to handle claims for injured IWIF employees. After the injury is reported to the HR department, a representative from SISCO will contact the employee regarding case management of their injury.

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.

IWIF Employee's Report of Injury

(To be completed by the employee only.)

Employee's name: _____ Male__ Female__
Last First Middle

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: _____
Address Area (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))

When did you report the accident to your supervisor? _____

Who did you report the injury to? _____

Do you require medical attention? Yes: _____ No: _____ Maybe: _____

Name of your treating physician: _____ Phone# _____

Signature of employee: _____ Date: _____

IWIF Accident Witness Statement

(To be completed by accident witness)

Injured employee's name: _____
Last First Middle

Name of witness: _____ Ph# _____
Last First Middle

Job title of witness: _____ How long employed here? _____

Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Location of accident: _____
Address/Name of building Area (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 Witnesses Supervisor: _____ Ph# _____
Last First

Signature of Witness: _____ Date: _____

IWIF Supervisor's Accident Investigation

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

Location where accident occurred		Employer's Premises: Yes <input type="checkbox"/> No <input type="checkbox"/> Job site: Yes <input type="checkbox"/> No <input type="checkbox"/>		Date of accident or illness
Who was injured?		<input type="checkbox"/> Employee <input type="checkbox"/> Non-Employee		Time of accident a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
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?			Property/equipment owned by:	
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? If so, what? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Nature and extent of injury/illness and property damaged (be specific)				

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Improper instruction | <input type="checkbox"/> Failure to lockout | <input type="checkbox"/> Unsafe arrangement or process |
| <input type="checkbox"/> Lack of training or skill | <input type="checkbox"/> Unsafe position | <input type="checkbox"/> Poor ventilation |
| <input type="checkbox"/> Operating without authority | <input type="checkbox"/> Improper dress | <input type="checkbox"/> Improper guarding |
| <input type="checkbox"/> Horseplay | <input type="checkbox"/> Improper protective equipment | <input type="checkbox"/> Improper maintenance |
| <input type="checkbox"/> Physical or mental impairment | <input type="checkbox"/> Unsafe equipment | <input type="checkbox"/> Inoperative safety device |
| <input type="checkbox"/> Failure to secure | <input type="checkbox"/> Poor housekeeping | <input type="checkbox"/> 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