

Employee Accident Investigation Report

This form is to be completed by the injured employee and the supervisor in charge at the time of the accident.

FACILITY

NAME	CITY	STATE	LOCATION #
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EMPLOYEE

NAME	SEX	D.O.B.	HEIGHT	WEIGHT
SOCIAL SECURITY #	HIRE DATE	FULL TIME <input type="checkbox"/>	PART TIME <input type="checkbox"/>	SHIFT: DAY <input type="checkbox"/> EVENING <input type="checkbox"/> NIGHT <input type="checkbox"/>
DEPARTMENT	ADDRESS			
JOB CLASSIFICATION	CITY, STATE	HOME PHONE # ()		

DESCRIPTION OF ACCIDENT

ACCIDENT DATE	ACCIDENT TIME	a.m. <input type="checkbox"/>	p.m. <input type="checkbox"/>	ACCIDENT LOCATION
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Please describe the accident, including what employee was doing when it occurred.

Name object or substance that directly attributed to the accident.

What caused the accident? How could it have been prevented?

Describe the injury.

B <input type="checkbox"/> 1. Abdomen O <input type="checkbox"/> 2. Ankle(s) D <input type="checkbox"/> 3. Back Y <input type="checkbox"/> 4. Buttock(s) <input type="checkbox"/> 5. Calf(s) <input type="checkbox"/> 6. Chest P <input type="checkbox"/> 7. Ear(s) A <input type="checkbox"/> 8. Elbow(s) R <input type="checkbox"/> 9. Eye(s) <input type="checkbox"/> 10. Face <input type="checkbox"/> 11. Finger(s) T <input type="checkbox"/> 12. Foot <input type="checkbox"/> 13. Forearm(s) <input type="checkbox"/> 14. Groin <input type="checkbox"/> 15. Hand(s) <input type="checkbox"/> 16. Head <input type="checkbox"/> 17. Hip(s) <input type="checkbox"/> 18. Jaw <input type="checkbox"/> 19. Knee(s) <input type="checkbox"/> 20. Leg(s) <input type="checkbox"/> 21. Lungs <input type="checkbox"/> 22. Mouth <input type="checkbox"/> 23. Neck <input type="checkbox"/> 24. Nose <input type="checkbox"/> 25. Ribs <input type="checkbox"/> 26. Shoulder(s) <input type="checkbox"/> 27. Spine <input type="checkbox"/> 28. Stomach <input type="checkbox"/> 29. Teeth <input type="checkbox"/> 30. Thigh(s) <input type="checkbox"/> 31. Throat <input type="checkbox"/> 32. Thumb(s) <input type="checkbox"/> 33. Toe <input type="checkbox"/> 34. Upper Arm(s) <input type="checkbox"/> 35. Whole Body <input type="checkbox"/> 36. Wrist(s)	C T O N P D E I T O I F O N	<input type="checkbox"/> 1. Abrasion <input type="checkbox"/> 2. Amputation <input type="checkbox"/> 3. Avulsion <input type="checkbox"/> 4. Blister <input type="checkbox"/> 5. Burn <input type="checkbox"/> 6. Contusion <input type="checkbox"/> 7. Death <input type="checkbox"/> 8. Dermatitis <input type="checkbox"/> 9. Foreign Object <input type="checkbox"/> 10. Fracture <input type="checkbox"/> 11. Frostbite <input type="checkbox"/> 12. Ganglion <input type="checkbox"/> 13. Grinding Wound <input type="checkbox"/> 14. Hearing Loss <input type="checkbox"/> 15. Heart Attach <input type="checkbox"/> 16. Heat (cramps, stroke) <input type="checkbox"/> 17. Hernia <input type="checkbox"/> 18. Infection <input type="checkbox"/> 19. Insect Bite <input type="checkbox"/> 20. Irritation (dust) <input type="checkbox"/> 21. Irritation (vapor) <input type="checkbox"/> 22. Laceration <input type="checkbox"/> 23. Pulmonary Condition <input type="checkbox"/> 24. Puncture Wound <input type="checkbox"/> 25. Repetitive Motion Disorder <input type="checkbox"/> 26. Scratch <input type="checkbox"/> 27. Sliver <input type="checkbox"/> 28. Splinter <input type="checkbox"/> 29. Sprain/Strain <input type="checkbox"/> 30. Slip/Fall <input type="checkbox"/> 31. Other _____
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Corrective actions taken to prevent recurrence.

Treatment

- First Aid
- Panel of Physicians
- Emergency Room
- Personal Physician/Clinic
- Refused Treatment
- Other (name) _____

Lost Time? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Days:	Modified/Restricted Duty <input type="checkbox"/> Yes <input type="checkbox"/> No	NUMBER OF DAYS
Did employee accept medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was employee hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did employee return to work the same day? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Report Date	Employee Signature	Supervisor Signature	