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 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: ______________________
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: (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: __________________

Accident Witness Statement
(To be completed by accident witness)
**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></td>
<td>Job site: Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>Who was injured?</td>
<td></td>
<td>Time of accident a.m. ☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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></td>
<td></td>
<td>How long has employee worked at job where injury or illness occurred?</td>
</tr>
<tr>
<td>What property/equipment was damaged?</td>
<td>Property/equipment owned by:</td>
<td></td>
</tr>
<tr>
<td>What was employee doing when injury/illness occurred?</td>
<td>What machine or tool was being used?</td>
<td>What type of 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/injured?</td>
<td>Any prior physical conditions? If so, what?</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**

- 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