



EMPLOYEE/SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Please Complete and Forward to Human Resources Within **24** hours of the Accident

EMPLOYEE COMPLETES:

Name: _____ Phone #: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Sex: _____ Marital Status: _____ Children: _____

Job Title: _____ Date of Hire: _____ Full-Time / Part-Time (CIRCLE ONE)

Date of Injury/Illness: _____ Time: _____ AM PM (CIRCLE ONE)

Time Employee's Shift Began on Date of Injury/Illness: _____ AM PM (CIRCLE ONE)

Place of accident or illness: _____ Address: _____

City: _____ Zip: _____

Describe the incident in detail: _____

NOTE: If medical attention is needed, the employee must go to Arrowhead Medical Center- Occupational Medicine & Wellness (ph. 575-5600) between the hours of 7:00 a.m. - 5:30 p.m. If the injury/illness occurs between the hours of 5:30 - 9:00 p.m. Monday through Friday, or 10:00am - 9:00 p.m. Saturday and Sunday, the employee must go to Covenant Convenient Care. The Emergency Room should be used ONLY if the above sites are closed or in a life threatening emergency.

Did employee seek medical attention for this injury/illness? Yes: _____ No: _____

*If Yes, employee must contact Human Resources to schedule an appointment on work injury procedures.

*If No, by signing this form, the employee must understand that waiving initial treatment could jeopardize future medical treatment for this injury/illness. Please contact Human Resources with questions.

Place of medical treatment: _____ Time of initial treatment: _____ a.m. / p.m.

My signature verifies that all information provided is accurate.

Employee: _____ Date: _____

SUPERVISOR COMPLETES THE REMAINDER:

What job or task was employee doing when injured or becoming ill? (Be specific, please.): _____

How did accident or illness occur? Describe the incident in detail. Attach additional sheets if necessary: _____

Name object or substance that most directly caused accident or illness: _____

Please list witnesses to the injury/illness: _____

PREVENTION:

Can anything be done to prevent a recurrence of this type of accident: (Maintenance of worksite/environment, modification of equipment, training, etc.): Yes / No (CIRCLE ONE)

If yes, please explain:

Date and person who was contacted to request correction: ___/___/___ _____

Did you discuss the accident with the employee and review ways to prevent a recurrence? Yes: _____ No: _____

Explain preventative measures discussed:

Was disciplinary action needed? (If so, please complete appropriate disciplinary action form.) Yes: _____ No: _____

This report is to be completed and signed by the employee and supervisor. **Please be sure ALL blanks are filled and/or all questions answered.**

Supervisor: _____

Date: _____