Chesapeake Employers Insurance™
Your workers' compensation specialist

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

Forms may be copied as needed. Forms are also available for printing in pdf format online at www.ceiwc.com.

Need Help?

If you would like assistance in setting up supervisory training on how to use these forms, please contact your Chesapeake Claims Adjuster or Safety Management Consultant at 1-800-264-4943.

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 ensures 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.

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

Please send the completed forms to your 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 his or her account of the accident to set the record straight and to help prevent the accident 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.

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Employee's Report of Injury

Policyholder: _____
Policy #: _____

(To be completed by the employee only.)

Employee's name: _____ Male____ Female____
Last First Middle

Date of birth: ____/____/____ Home telephone # (_____) _____

Marital status: Married Height/Weight: _____" /_____ lbs. ____Right- or ____left-hand dominant

Home address: _____

City: _____ State: _____ Zip Code: _____

Current job position: _____ How long employed here: _____

Social Security No.: _____-_____-_____ Weekly salary: _____

Location of accident:_____
Address and location of accident (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? _____

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: _____
Note: form must be signed by hand

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Accident Witness Statement

Policyholder: _____
Policy #: _____

(To be completed by accident witness.)

Injured employee's name: _____
Last First Middle

Name of witness: _____ Phone # _____
Last First Middle

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

Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Is witness any relation to the injured employee? ___Yes ___No If yes, what relation? _____

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 witness' supervisor: _____ Ph # _____
Last First

Signature of witness: _____ Date: _____
Note: form must be signed by hand

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Supervisor's Accident Investigation Form

Policyholder: _____

Policy #: _____

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

Location where accident occurred:		Employer's Premises: Yes ☐ No ☐ Job site: Yes ☐ No ☐	Date of accident or illness:
Who was injured?		Employee ☐ Non-employee ☐ If non-employee, specify_____	Time of accident a.m. ☐ p.m. ☐
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.			
Was the accident the result of another party's negligence?		If so, name of the negligent party:	
Part of body affected/injured?		Any prior physical conditions? If so, what? Yes ☐ No ☐	
Nature and extent of injury/illness and property damaged (be specific):			
Do you have any concerns about this alleged accident or injury? If so, please specify:			

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

____ Failure to lockout
____ Failure to secure
____ Horseplay
____ Improper dress
____ Improper guarding
____ Improper instruction
____ Improper maintenance
____ Improper protective equipment
____ Inoperative safety device
____ Lack of training or skill
____ Operating without authority
____ Physical or mental impairment
____ Poor housekeeping
____ Poor ventilation
____ Unsafe arrangement or process
____ Unsafe equipment
____ Unsafe position
____ 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 using the appropriate Personal Protective Equipment/proper safety procedures at the time?....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

Note: form must be signed by hand