Call QualLynx at 877-822-9368

# ACCIDENT INVESTIGATION REPORT

***Immediate completion of this form will help us to assist employees in obtaining workers' compensation benefits and help us prevent injuries to others.***

Insured:_____ Today's Date:_____

Department:_____ Time:_____

| Part 1 EMPLOYEE MUST COMPLETE AND ANSWER ALL QUESTIONS | | | | |
|---|---|---|---|---|
| First Name | M.I. | Last Name | Your Usual Occupation | Date of Birth / / |
| Home Address (Number and Street) | | City | State | Zip |
| Home Phone # ( ) | Sex ☐ Male ☐ Female | Marital Status | Length of Time Employed | |
| Date and Time of Accident ☐AM ☐PM | | Exact Location Where Accident Occurred | | |
| Occupation at Time of Accident | | On Employer's Premises? ☐ Yes ☐ No | | |
| Employee's Complete Description of Accident (Give details in explaining what happened.) | | | | |
| | | | | |
| | | | | |
| Description of Injury (Give details including part of body injured.) | | | | |
| | | | | |
| Did anyone witness this accident? ☐ Yes ☐ No<br>Witness Name(s): | | | | |
| Employee's Signature | | Social Security # | | |

**SHOULD BE COMPLETED BY EMPLOYEE'S DIRECT SUPERVISOR**

**Part 2 TO BE COMPLETED BY SUPERVISOR TO WHOM ACCIDENT REPORTED – REPORT ALL HAZARDS IMMEDIATELY!**

Supervisor's name and title:_____

1. Do you usually supervise this individual? ☐ Yes ☐ No For how long?_____
2. Was accident immediately reported? ☐ Yes ☐ No* (Explain below) (If no, when and how did you learn of the accident?)
3. Was employee working ☐ alone* (Explain below) ☐ with crew or fellow workers?
4. Was employee at work on company time? ☐ Yes ☐ No* (Explain below)
5. Did you physically inspect the area where injury occurred? ☐ Yes ☐ No* (Explain below)
6. Any unsafe conditions or unusual hazards present? ☐ Yes* ☐ No

7. Evidence of horseplay? ☐ Yes* ☐ No
8. Evidence of intoxication? ☐ Yes* ☐ No
9. Evidence of drug use? ☐ Yes* ☐ No
10. Was employer provided safety equipment in use? ☐ Yes ☐ No*
11. Was immediate medical attention necessary? ☐ Yes ☐ No If yes, where?_____

_____

By whom?_____
12. Is employee at work now? ☐ Yes ☐ No If no, when do you expect employee to return?_____

_____
13. Are you satisfied that the accident/injury occurred as described above? ☐ Yes ☐ No*
14. Do you feel that accidents such as this can be avoided in the future? ☐ Yes* ☐ No
15. Describe action(s) taken to prevent recurrence: (safety talk with employees, eliminate unsafe practice, remove hazards, etc.)_____

_____
16. Do you want to discuss this matter with the Claim Representative? ☐ Yes* ☐ No
17. Was employee wearing back support? ☐ Yes ☐ No*

**Explain all * items by number**

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Prepared by:_____ Dept.:_____ Date:_____

Signature