

Chesapeake Accident Investigation FORMS

How to use these important TOOLS

Includes:

Employee's Report of Injury Form

> **Accident Witness Statement Form**

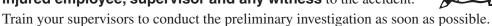
Supervisor's Accident **Investigation Form**

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.



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.



Employee's Report of Injury

Policyholde	er:	
Policy #: _		

To be completed by the employee only.) Employee's name: ______ Male___Female___ Date of birth: ____/___ Home telephone # (_____) _____ Marital status: M / D / W / S 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: Phone #_____ Name of supervisor: ______ 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 # Note: form must be signed by hand Signature of employee: ___



Accident Witness Statement

Policyholder:	
Policy #:	

	 (To be completed be 	y accident witne	ss.)
	_		
Injured employee's name:			
injured emproyee shame.	Last	First	Middle
Name of witness:			Phone#
Last	First	Middle	
Job title of witness:			How long employed here?
Home address of witness:			
			Zip Code:
Is witness any relation to the injur	red employee?Y	esNo If ye	es, what relation?
Location of accident:			
Date of accident:		Т	Cime of accident:
Describe fully how accident occur	red (including events	s that occurred i	immediately before the accident):
		() 00	
Describe bodily injury sustained (be specific about bod	y part(s) affecte	d):
Recommendation on how to preven	nt this accident from 1	ecurring:	
Name of witness' supervisor:			Ph #
	Last	First	
Cianatura of witness.			Dotor
Signature of witness:	form must be signed by har	nd	Date:



Supervisor's Accident Investigation Form

Policyholder:	
Policy #:	

Location where accident occurred:		oyee's supervisor or other responsible adminis Employer's Premises: Y	Date of acciden	nt or illness:	
		Job site: Yo		Date of acciden	it of fifficss.
Who was injured?		Employee Non-employee		Time of accider	nt a.m.
		If non-employee, specify			p.m.
Length of time with firm:	Job title or occupation:	Name of dept. normally assigned to:	Name of dept. normally assigned to: How long has where injury		ed?
What property/equipment	was damaged?		Property/equipment owned by:		
What was employee doing	when injury/illness occurred	d? What machine or tool was being used? V	What type of op	peration?	
How did injury/illness occi	ur? List all objects and su	ibstances involved.			
W. d. d. d.					
	t of another party's negligeno		-		
Part of body affected/injure	ed?	Any prior physical conditions?	If so, what?		
Nature and extent of injury	/illness and property damag	Yes No No red (be specific):			
	,	,			
Do you have any concerns	about this alleged accident of	or injury? If so, please specify:			
PLEASE INDICATE	ALL OF THE FOLL	OWING WHICH CONTRIBUTED	TO THE I	 NJURY OR I	LLNESS
Failure to lockout		_ Improper maintenance		usekeeping	
Failure to secure		_ Improper protective equipment	Poor ventilation		
Horseplay		_ Inoperative safety device	Unsafe	_ Unsafe arrangement or process	
Improper dress		Lack of training or skill	Unsafe equipment		
Improper guardin	g	Operating without authority _		safe position	
Improper instructi	on	Physical or mental impairment _	Other _		
Supervisor's corrective	action to ensure this type	e of accident does not recur:			
		Personal Protective Equipment/proper	• •		
Was employee using the	e appropriate Personal P	Protective Equipment/proper safety proc	edures at the	time?Yes _	No
Did employee promptly	report the injury/illness	s?		Yes _	No
Is there modified duty a	vailable?			Yes	No
Supervisor's	nama	Supervisor's signature	Phone		Date
Supervisor s		Note: form must be signed by hand	FIIOILE	π	Date