IWIF

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.

Accident investigation forms/statements **should be filled out** by the **injured employee, supervisor or 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.

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

Hold on to them. When you call the COMPcall injury hotline to report the accident, advise the operator that these forms were completed or if you are planning to have the forms completed. Please keep the completed forms for future reference and inform the IWIF claims adjuster you have them if needed. These completed forms can be valuable information in the claims investigation of an injury and for building a case 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.

Need Help?

If you would like assistance in setting up supervisory training on how to use these forms, please contact your IWIF loss control consultant or call 410-494-2071.

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IWIF Employee's Report of Injury

(To be completed by the employee)

Employee's name: Male Female

Last First Middle

Date of birth: / / Home Telephone # ( )

Home Address:

City: State: Zip Code:

Present classification: How long employed here:

Social Security No.: - - Bi-weekly salary:

Location of accident:

Name of building Area (bathroom, etc.)

Date of accident: Time of accident:

Describe fully how accident occurred:

(continue on other side, if necessary)

Describe bodily injury sustained (be specific about body part(s) affected):

Recommendation on how to prevent this accident from recurring:

(continue on other side, if necessary)

Name of Supervisor:

Last First Middle

Name(s) of Witness(es):

(Attach witness(es) report(s))

When did you report the accident to your supervisor?

Signature of employee: ____ Date: ______________________

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IWIF Accident Witness Statement

(To be completed by accident witness)

Injured Employee's name:
Last First Middle

Name of Witness:
Last First Middle

Job title of Witness: How long employed here?

Home address of witness:

City: State: Zip Code:

Location of accident:
Address/Name of building Area (bathroom, etc.)

Date of accident: Time of accident:

Describe fully how accident occurred:

(continue on other side, if necessary)

Describe bodily injury sustained (be specific about body part(s) affected):

Recommendation on how to prevent this accident from recurring:

(continue on other side, if necessary)

Name of Supervisor:
Last First Middle

Signature of Witness: ____ Date: ______________________

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Supervisor's Accident Investigation

(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	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 was damaged?			Property owned by	
What was employee doing when injury/illness occurred? What machine or tool? What operation?				
How did injury/illness occur? List all objects and substances involved.				
Part of body affected	Any prior physical defects? If so, what? Yes ☐ No ☐			
Nature and extent of injury/illness and property damaged (be specific)				

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

Improper instruction	Failure to lockout	Unsafe arrangement or process
Lack of training or skill	Unsafe position	Poor ventilation
Operating without authority	Improper dress	Improper guarding
Horseplay	Improper protective equipment	Improper maintenance
Physical or mental impairment	Unsafe equipment	Inoperative safety device
Failure to secure	Poor housekeeping	Other

Supervisor's corrective action to insure this type of accident does not reoccur:

Was employee retrained 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

Supervisor's name | Supervisor's signature | Date

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Form may be copied as needed

First Report of Injury
Required UMCES Supplement
To Be Completed by Employee's Supervisor

Employee's Name: Work Phone #:

UMCES Policy Number: 910962

Marital Status: ☐Unknown ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

# of dependent children:

Was any time lost from work: ☐Yes ☐No If so, how many hours/days?:
If fatal, date of death: / /

Initial Treatment

Minor by Employer:	☐Yes	☐No	
Minor by Clinic/Hospital:	☐Yes	☐No	☐Unknown
Emergency Care:	☐Yes	☐No	☐Unknown
Hospitalized:	☐Yes	☐No	
Machine/Product Failure:	☐Yes	☐No	
Vehicular Accident:	☐Yes	☐No	

Has claimant returned to work: ☐Yes ☐No If so, when: / /

Full pay for date of injury: ☐Yes ☐No ☐Unknown
Did salary continue? ☐Yes ☐No ☐Unknown

# of days worked/week:

Time workday began:_______ ☐AM / ☐PM

Did injury, illness or exposure occur on employer's premises?: ☐Yes ☐No ☐Unknown

Were safeguards/safety equipment provided?: ☐Yes ☐No ☐Unknown
Were they used?: ☐Yes ☐No ☐Unknown

Performing regular duties?: ☐Yes ☐No ☐Unknown

Do you agree with employee's version of accident: ☐Yes ☐No
If no, explain:

Supervisor's Signature: ____ Date: _____________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(LIMITED FOR USE WHEN STATE OF MARYLAND IS THE EMPLOYER)

TO: ___________________________________
(Name of Record Holder)

PATIENT-CLAIMANT NAME: SSN: DATE OF BIRTH: DATE OF INJURY:

/ / / /

I hereby authorize you to give to:

INJURED WORKERS' INSURANCE FUND (IWIF) OR DESIGNATED REPRESENTATIVE
(Name of Record Requestor)

a copy of all information you may have in my medical record regarding the condition of the following part or parts of my body of my medication condition:

(Specify part or parts of body or medical condition.)

____

____

____

while under your observation or treatment or otherwise in your possession. This includes, but is not limited to, history, findings, office and patient charts and files, examination and progress notes, physical evidence, x-rays and diagnostic test results, access to and disclosure of hospital or other health care provider records contained in my medical record, whether prepared by you or by another health care provider, and any subsequent or future developments relating to my health or mental condition.

This authorization is subject to the requirement that the requestor sends a copy of the transmittal letter to the Claimant or his/her attorney and that a copy of all material received pursuant to this authorization is promptly supplied to the Claimant or his/her attorney, as is required by the regulations of the Workers' Compensation Commission. IWIF is acting as agent for the State of Maryland, employer of the claimant, when IWIF requests copies of medical records. Copies of these records obtained by IWIF may be provided to the State of Maryland.

____
SIGNATURE

____
DATE OF REQUEST

8722 Loch Raven Blvd.
Towson, MD 21286
410-494-2000

Physician's Evaluation

An important aspect of our company's Return-to-Work Program is returning an injured employee to work as soon as medically able after the date of injury. Please provide the following information so that we can best determine the physical limitations of the employee and, if necessary, place the employee in a suitable temporary modified job.

Employer/Injured Employee Information (To be completed by the employer prior to the physician's office visit)

Employer:______________________ Contact Person: ______________________

Address:______________________ City:____________ State:_____ Zip:_________

Employers phone number: (_____) ______-_________ Insurance Carrier: Injured Workers' Insurance Fund

Name of Injured Employee:______________________ Employee SSN ______-____-_______

Employee phone number: (_____) ______-__________ Date of Injury:___/___/___ Claim # ____________

Occupation:______________________ Type of Injury:______________________

Physicians Evaluation (To be completed by the physician)

Diagnosis:______________________

Treatment:______________________

Patient is able to lift: Please check the exact degree of work you feel this patient is capable of performing. U.S. Dept. of Labor classifies five degrees of work in terms of lifting requirements.

____ **Sedentary Work:** Lifting 10 pounds maximum and occasionally lifting and/or carrying small articles and occasional walking and standing.
____ **Light Work:** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. It involves sitting most of the time with a degree of pushing/pulling of arm and/or leg controls.
____ **Medium Work:** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects up to 25 pounds.
____ **Heavy Work:** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects no more than 50 pounds.
____ **Very Heavy Work:** Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.

In an eight hour day, patient is able to perform at the following level:

Occasionally = <33% per day Frequently + 33%-66% per day Constantly = >66% per day

Stand	____ Not at all	____ Occasionally	____ Frequently	____ Constantly
Walk	____ Not at all	____ Occasionally	____ Frequently	____ Constantly
Sit	____ Not at all	____ Occasionally	____ Frequently	____ Constantly
Drive	____ Not at all	____ Occasionally	____ Frequently	____ Constantly
Bend	____ Not at all	____ Occasionally	____ Frequently	____ Constantly
Squat	____ Not at all	____ Occasionally	____ Frequently	____ Constantly
Climb	____ Not at all	____ Occasionally	____ Frequently	____ Constantly
Push/Pull ...	____ Not at all	____ Occasionally	____ Frequently	____ Constantly
Grasp	____ Not at all	____ Occasionally	____ Frequently	____ Constantly
Manipulate .	____ Not at all	____ Occasionally	____ Frequently	____ Constantly

Patient can be exposed to:

Unprotected heights	___ Not at all	____ Occasionally	____ Frequently	____ Constantly
Uneven surfaces	___ Not at all ...	____ Occasionally	____ Frequently	____ Constantly
Marked changes in temperature and humidity	___ Not at all ...	____ Occasionally	____ Frequently	____ Constantly

The above restrictions are: ____ Permanent ____ Temporary until ______________

Can resume **modified** work duties on:____________ Can resume **full (regular) work** duties on:____________

Other restrictions or comments: ______________________

Medical facility: ______________________

Address:______________________ Phone:____________

Physicians name:______________ Physicians signature:______________ Date:________

Please fax a copy of this completed evaluation to: ______________ @Fax# ____________
(IWIF Nurse Case Manager or Claims Adjuster)