

ACCIDENT INVESTIGATION – Workers' Compensation Injury
TO BE COMPLETED BY SUPERVISOR OR DESIGNEE
PROVIDING EMPLOYEE INFORMATION/OTHER

1. Employee Name (Last, First Middle)		2. Home Address	
3. School/Site/Department /Name/Department		4. Work Phone	5. Home Phone
6. Job Title	7. Length of Time Employed by System	8. Time & Date of Injury	9. Time & Date Reported
10. Time Shift Begins: Ends:	11. Length of Time in Present Job	12. Injury Classification ☐ First Aid ☐ Fatality ☐ Medical ☐ Lost Time	
13. Hours Worked per Day	14. Social Security No.	18. If Doctor reports that employee is incapacitated, date incapacitation began? (mm/dd/yyyy)	
15. Date of Birth (mm/dd/yyyy)	16. Age	17. Sex ☐ MALE ☐ FEMALE	22. Address & Phone of Doctor/Hospital:
19. Marital Status ☐ Married ☐ Single ☐ Widower ☐ Widow ☐ Divorced	20. DATE EMPLOYEE RETURNED TO WORK		
21. Did Employee visit a Doctor/Hospital? ☐ YES: If yes, please answer #s 18, 22, & 23 ☐ NO			
23. Name of Doctor and/or Hospital?			
24. Describe the events that led up to the incident (state what happened, machine/tool being used, etc.)			
25. Describe clearly what injury/illness was incurred [Body Part(s) involved].			
26. Specific location of incident (Facility, Room #, etc.)			
27. Name/Address/Work Phone of Witness(es)			
28. Signature of Person Completing Form		29. Date (mm/dd/yyyy)	
30. Has a Work Order been generated to correct the situation? (If yes, please answer #31) ☐ Yes ☐ NO		31. Date Work Order was generated (mm/dd/yyyy)	
32. What acts/failures to act contributed to this incident?			
33. What workplace conditions existed that contributed to this incident?			
34. What action has been or will be taken to prevent recurrence?			
36. Supervisor's Name: (Print)		37. Supervisor's Job Title:	
38. Supervisor's Signature		39. Date (mm/dd/yyyy)	

PRINCIPAL OR SUPERVISOR