WORKER'S COMPENSATION ACCIDENT/INCIDENT REPORT
Claims Reporting Hotline: 866-415-8821

Client Company Name: _____

Address: _____

City, State, Zip: _____

Contact Person: _____

Phone: _____

Email Address: _____

ATTENTION:
This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains. In addition, this form is required for each injury/illness recorded on your OSHA 300 log, regardless of whether or not the injury/illness is compensable per Workers' Compensation.

SECTION 1: GENERAL INFORMATION

REPORTED BY: _____ DATE REPORTED TO MGR: _____

INVESTIGATED BY: _____ DATE OF INVESTIGATION: _____

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____ ☐ AM ☐ PM

LOCATION OF INCIDENT: _____

INJURED EMPLOYEE: _____ (N/A No Employees Were Injured)

WITNESS(ES): _____

WHAT WAS THE EMPLOYEE DOING IMMEDIATELY BEFORE THE INCIDENT OCCURRED:

DESCRIBE WHAT HAPPENED:

DESCRIBE WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE:
(ie, concrete floor; chlorine; radial arm saw. If this question does not apply to the incident, leave it blank)

DESCRIBE ANY RELATED SAFETY TRAINING PROVIDED PRIOR TO THE INCIDENT:

WAS PPE WORN? Yes ❑ No ❑ N/A WAS PPE REQUIRED? ❑ Yes ❑ No

TYPE: _____

SECTION II: ROOT CAUSE AND PREVENTITIVE ACTION

WHAT IS THE ROOT CAUSE OF THE INCIDENT OR ACCIDENT:

DESCRIBE ANY CORRECTIVE ACTION TAKEN TO PREVENT RE-OCCURANCE:

SECTION III: INJURED OR ILL EMPLOYEE INFORMATION

DATE OF INJURY/ILLNESS: _____ TIME OF INJURY / ILLNESS: _____ ☐ AM ☐ PM

NAME: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ PHONE: _____

DATE OF HIRE: _____ DATE OF BIRTH: _____

TIME EMPLOYEE BEGAN WORK / SHIFT ON THE DATE OF INJURY: _____ ☐ AM ☐ PM

SECTION IV: INJURY/ILLNESS INFORMATION

BODY PART AFFECTED:
(Ex: Left Index Finger) _____

TYPE OF INJURY / ILLNESS:
(Ex: Sprain, Laceration, Fracture) _____

FIRST AID PROVIDED:
(Ex: Flushed Eyes w/ Water) _____

WAS MEDICAL TREATMENT BY A PHYSICIAN REQUIRED FOR TREATMENT: ☐ YES ☐ NO

If yes, complete sections V through VI and report the injury by calling Advantage Personnel Resources at 1-866-415-8821. Completion of this investigation report is not a substitute for reporting the claim.

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SECTION V: MEDICAL TREATMENT RENDERED

DATE THE EMPLOYEE RECEIVED MEDICAL TREATMENT: _____ ☐ Refused By Employee

SIGNATURE OF EMPLOYEE IF REFUSED: _____ DATE: _____

NAME OF MEDICAL FACILITY: _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ Z1PCODE: _____

TYPE: ☐ Hospital Emergency Room ☐ Walk-In Medical Clinic ☐ Authorized Physician's Office

WAS THE INJURY FATAL? ☐ YES ☐ NO IF YES, ENTER DATE OF DEATH: _____

SECTION VI: REPORTING & RECORD- KEEPING REQUIREMENTS

DATE INJURY OR ILLNESS WAS REPORTED TO INSURANCE CARRIER: _____

INSURANCE CARRIER CLAIM NUMBER: _____

WAS THE INJURY REPORTED TO INSURNCE CARRIER WITHIN 24HR5 HOURS? ☐ YES ☐ NO
NO, PLEASE EXPLAIN WHY NOT:

WAS A POST-ACCIDENT DRUG TEST PERFORMED? ☐ YES ☐ NO
NO, PLEASE EXPLAIN WHY NOT:

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WAS THE INJURY ENTERED ON THE OSHA 300 LOG? ☐ YES ☐ NO CASE LOG#: _____

SECTION VII: SIGNATURES

INJURED EMPLOYEE: _____ DATE: _____

INVESTIGATOR: _____ DATE: _____

MANAGEMENT REVIEW AND FOLLOW-UP ACTION:

REVIEWED BY: _____ REVIEWED ON: _____

FOLLOW-UP ACTION PLAN:

_____

_____

_____

FOLLOW-UP COMPLETED ON: _____ SIGNATURE: _____

NOTES:

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WITNESS STATEMENT 1:

PUT IN YOUR OWN WORDS WHAT YOU SAW HAPPEN.

WITNESS SIGNATURE: _____ DATE: _____

WITNESS STATEMENT 2:

PUT IN YOUR OWN WORDS WHAT YOU SAW HAPPEN.

WITNESS SIGNATURE: _____ DATE: _____