



## ACCIDENT INVESTIGATION FORM

---

### **A: INCIDENT TYPE**

- INCIDENT-NO INJURY     MINOR INJURY-NO TREATMENT     FIRST AID     HEALTH CARE     LOST TIME  
 CRITICAL INJURY     OCCUPATIONAL DISEASE

---

### **B: EMPLOYEE INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

PERSONNEL NUMBER: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

POSTAL CODE: \_\_\_\_\_

HOME TELEPHONE: (\_\_\_\_) \_\_\_\_\_ WORK TELEPHONE: (\_\_\_\_) \_\_\_\_\_

JOB TITLE: \_\_\_\_\_ DATE OF HIRE: \_\_\_\_\_

YEARS OF EXPERIENCE: \_\_\_\_\_ S.S NUMBER: \_\_\_\_\_  
(years experience in occupation)

DATE OF BIRTH: \_\_\_\_\_ SEX:    M    F

EMPLOYEE GROUP:     Clerical     Stage Hand     Crew     Actor  
                                   Other (specify) \_\_\_\_\_

STATUS:     FULL TIME     PART TIME     CASUAL     SESSIONAL     TEMPORARY  
 OTHER (provide details) \_\_\_\_\_

---

### **C: REPORTING**

DATE AND TIME OF INCIDENT: \_\_\_\_\_

DATE AND TIME REPORTED: \_\_\_\_\_

NAME OF MANAGER TO WHOM ACCIDENT WAS REPORTED: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

IF THERE WAS A DELAY IN REPORTING THIS ACCIDENT, LIST REASON(S):  
\_\_\_\_\_  
\_\_\_\_\_

IF FIRST AID WAS PROVIDED, GIVE NAME OF PROVIDER: \_\_\_\_\_

WAS MEDICAL ATTENTION SOUGHT?     YES     NO

*IF YES, PLEASE COMPLETE THE FOLLOWING LINE:*

NAME AND ADDRESS OF ATTENDING PHYSICIAN/HOSPITAL:  
\_\_\_\_\_  
\_\_\_\_\_

---

### **D: ACCIDENT/OCCUPATIONAL DISEASE DETAILS-STATE EXACTLY (attach letter if required)**

1. DESCRIBE THE INJURY, PART OF BODY INVOLVED, AND SPECIFY LEFT OR RIGHT SIDE.

2. WHAT HAPPENED TO CAUSE THE INJURY?

3. EXPLAIN WHAT THE EMPLOYEE WAS DOING AND THE EFFORT INVOLVED.
  
4. IDENTIFY THE SIZE, WEIGHT, AND TYPE OF EQUIPMENT OR MATERIAL INVOLVED.
  
5. WHERE DID THE ACCIDENT OCCUR? (location, building, room number)
  
6. WHAT CONDITIONS ATTRIBUTED TO THE ACCIDENT AND WHAT STEPS HAVE BEEN TAKEN TO PREVENT RECCURANCE?
  
7. NAME AND WORK ADDRESS OF ANY WITNESSES:

---

**E: ADDITIONAL INFORMATION** *complete if time was lost from work*

DATE AND HOUR LAST WORKED: \_\_\_\_\_

NORMAL WORKING HOURS ON LAST DAY WORKED: \_\_\_\_\_

RATE OF PAY:  HOURLY \_\_\_\_\_  DAILY \_\_\_\_\_ TOTAL WEEKLY PAY HOURS: \_\_\_\_\_

SHIFT WORKER:  YES  NO IF YES, ENTER SHIFT PREMIUM: \$\_\_\_\_\_ per hour

CIRCLE EMPLOYEE'S USUAL WORK DAYS:

Sunday:      Monday:      Tuesday:      Wednesday:      Thursday:      Friday:      Saturday:

ESTIMATED TIME OFF WORK: \_\_\_\_\_ (days / shifts)

---

**G: CLAIM INFORMATION**

To your knowledge, has the worker had a previous similar injury/disease?  YES  NO

If yes, provide details and whether a similar injury was work related or not.

Was any individual who does not work for you totally or partially responsible for the injury/disease?  YES  NO

If yes, please explain.

If machinery, equipment or a motor vehicle was totally or partially responsible for the injury/disease, refer to the instructions on the reverse of the Employer's Copy and provide particulars.

Do you have any reason to doubt that the injury/disease is work-related?  YES  NO

If yes, please explain.

**TO BE SIGNED BY DEPARTMENT HEAD OR EMPLOYEE'S SUPERVISOR**

COMPLETED BY: (please print)

TITLE:

\_\_\_\_\_

\_\_\_\_\_

SIGNATURE:

DATE:

TELEPHONE:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **WHEN TO COMPLETE THIS FORM**

*The State Board of Worker's Compensation requires that employers file a report within three days of learning of an occupational injury or disease that disables an employee or requires health care. Failure to do so may result in a late filing penalty being levied.*

*Please print clearly in ink. If all of the information is not immediately available to you, please send what you have and submit further information as soon as you have it. If additional space is required, attach a separate letter.*

## **TYPES OF INJURIES**

### **NON-INJURY**

Refers to an accident in which there was no personal injury, but which has the potential for personal injury.

### **MINOR-INJURY**

When an injury occurs but does not require treatment by a first-aider or by a health professional.

### **FIRST AID**

When an injury occurs but the employee does not require health care, but only the treatment of a first-aider, nurse, or non-medical.

### **HEALTH CARE**

An employee seeks medical attention from a health professional i.e. doctor, hospital, chiropractor, specialist, or dentist but does not lose any time from work beyond the accident date.

### **LOST TIME**

When an employee does not report for work on the next scheduled shift as a result of a work related injury.

### **OCCUPATIONAL DISEASE OR ILLNESS**

Refers to a condition that results from exposure in a workplace to a physical, chemical, or biological agent to the extent that the normal physiological mechanisms are affected and the health of the employee is impaired.

## **EMPLOYEE RESPONSIBILITIES**

1. Promptly receive first aid.
2. Notify your manager immediately of any injury, including injuries which do not require medical attention or lost time.
3. Choose a doctor or other qualified practitioner (hospital, doctor, chiropractor, dentist).
4. In the case of a lost time injury, keep your supervisor updated as to your progress.

## **MANAGER RESPONSIBILITIES**

1. Ensure that first aid is received.
2. Provide transportation for the employee to a medical facility or to their home.
3. Investigate the accident and determine causes and make necessary changes.
4. Send a completed accident report to the Human Resources Department within 24 hours.

## **CRITICAL INJURY IS DEFINED AS AN INJURY OF A SERIOUS NATURE THAT:**

- (a) places a life in jeopardy
- (b) produces unconsciousness
- (c) results in substantial loss of blood
- (d) involves the fracture of a leg or arm but not a finger or toe
- (e) involves the amputation of a leg, arm, hand or foot, not a finger or toe
- (f) consists of burns to a major part of the body
- (g) causes the loss of sight in an eye

EXAMPLES OF ALTERED STATE OF CONSCIOUSNESS COULD INCLUDE NEAR DROWNING, ELECTRIC SHOCK, OR SEIZURE.

## **IN THE EVENT OF A CRITICAL INJURY, MANAGERS ARE RESPONSIBLE FOR:**

1. Procuring immediate medical attention.
2. Notifying the Human Resources Department
3. Ensuring the site of the accident remains undisturbed until the investigation has been completed.
4. Preparing a written report of the circumstances of the accident.