Employee Work Related Injury / Illness Investigation Form

A: Location Data

Name of Location_____

Address_____Phone Number_____/__ _____-_____

B: Employee Data

Employee Name_____ Job Title_____

Home Address_____

Primary Phone Number_____/_____-_____

Date of Birth____/____/____ Years of Service____ Social Security Number__ __ __/__ __/__ __ __

Male ☐ Female ☐ Married Yes ☐ No ☐ Number of Children Under18? _____

C: Accident Data

Date of Accident____/____/____Time____:____AM/PM

Date Employee Reported Accident____/____/____

Will there be lost time? Yes ☐ No ☐ How long?____

Exact location of accident (include building location)_____

_____

Object injuring employee_____

Was medical treatment sought? Yes ☐ No ☐ When?_____

Name and address of physician/hospital/urgent care facility where treatment was sought

_____

_____

D: Loss Cause Analysis

Type of Accident (Please check one)

- ☐ 01 Struck by object
- ☐ 02 Struck by student/ employee
- ☐ 03 Cut, puncture, bite, or scrape
- ☐ 04 Caught in, between, or under
- ☐ 05 Slip, trip, or fall
- ☐ 06 Strain due to lifting
- ☐ 07 Strain due to pushing, pulling
- ☐ 08 Strain, misc.
- ☐ 09 Burn
- ☐ 10 Occupational dermatitis
- ☐ 11 Occupational illness, misc.
- ☐ 12 Foreign body in eye
- ☐ 13 Other, specify_____

Injured body part (Please check one/circle right or left)

- ☐ 01 Eye
- ☐ 02 Head (ear, face, teeth, etc.)
- ☐ 03 Trunk
- ☐ 04 Back/ Neck
- ☐ 05 Abdomen
- ☐ 06 Shoulder, arm, elbow (Right/Left)
- ☐ 07 Hand, wrist, fingers (Right/Left)
- ☐ 08 Leg, knee, ankle (Right/Left)
- ☐ 09 Foot, toe (Right/Left)
- ☐ 10 Other, specify_____

PLEASE COMPLETE NEXT PAGE

E: Description of Incident (please describe in detail what happened)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

F: Witnesses to Incident (Please list name of any employees who witnessed incident)

Witness #1_____

Witness #2_____

Witness #3_____

_____	_____	____/____/____
Signature of Injured Employee	Title	Date
_____	_____	____/____/____
Signature of Person Completing this Report (If completing on injured employee's behalf)	Title	Date
_____	_____	____/____/____
Supervisor / Principal Signature	Title	Date