



## How the Investigator Completes the Employee Accident Investigation Report

### *General Directions*

1. Complete the report within 24 hours of the accident.
2. Use a ballpoint pen.
3. Write legibly and clearly.
4. Complete ALL times.

### *Detailed Directions*

1. Employee Name/Facility/Position/Department/Date of Hire/Date of Injury/Time of Injury Date Reported

These are all self-explanatory. Be specific and accurate in reporting this information.

2. Describe injury and first-aid treatment (or indicate sent to E.D.)

This requires the supervisor/investigator to know the nature of the injury such as laceration, foreign body in the eye, burn, back or shoulder strain, bruise or fracture. (BE SPECIFIC -- for example, foreign body in left eye.) The investigator must also know the type of treatment given; such as, cleaned wound and bandaged, applied ace bandage, gave tetanus shot, reset bone and placed in cast, or required to stay in bed until healed. If the investigator is unfamiliar with type of treatment and the employee is sent to E.D., the Employee Health Nurse will follow up.

3. Describe the accident thoroughly, (what happened; i.e., location of accident, actions, tools conditions)

This requires the supervisor/investigator to gather all the facts about the accident. From this description, the supervisor/investigator will be able to complete the rest of the form. (Include a photograph when possible.) Without a full description, the supervisor/investigator and management will not be able to take meaningful corrective action to prevent a similar accident.

The description should take into consideration such information as:

- a. The employee's physical/mental state.
  - b. The task being done.
  - c. Location of accident.
  - d. Equipment being used.
  - e. Safe/unsafe conditions in the work environment?
  - f. Availability and use of personal protective equipment (goggles, hard hat, steel-toe shoes, respirator, harness, hearing protection, etc.).
  - g. Did employee have enough information to do the job safely?
  - h. Was the employee rushing to get the job done due to pressures?
  - i. Were established procedures followed?
4. Immediate Cause of Injury

This is the supervisor's/investigator's determination of what was THE activity or condition directly responsible for the accident. Activity may mean any action taken or done by the employee, the supervisor, or another employee. The activity may even be a particular procedure, technique or method.

i. Other Contributing Causes

Very few accidents have only one cause. Most accidents are multi-causal. For example, the immediate cause for an employee's slipping and falling may be the unsafe presence of an oil spot. Contributing causes could include:

- a. Failure of the employee who spilled the oil to clean it up.
- b. Failure of the supervisor to ensure that oil spots are cleaned up (i.e., failure to enforce good housekeeping).
- c. Lack of equipment to clean up oil spots.
- d. The injured employee's running to leave work at the end of the day.
- e. Failure to repair the oil leak on the machine from which the oil dripped/spilled.

5. Thoroughly describe all corrective actions implemented as a result of the above accident causes.

Such corrective actions should be a result of having determined the immediate and contributing causes for the accident.

For example: Corrective actions for the above-noted example could be:

- a. The supervisor has been told to require all employees to clean up spills, drips, and leaks immediately.
- b. The supervisor's employees have begun to clean-up spills, drips, and leaks immediately and will continue to ensure good housekeeping.
- c. Employees have been given "oil-dry" to put on oil spots to improve the clean-up process.
- d. The injured employee has been told to walk in the facility at all times, since running is dangerous.
- e. The oil leak has been repaired, and employees are reporting leaks whenever they are found.

7. What follow-up actions will be taken to prevent another occurrence?

Analyze causes without blaming the injured worker.

7a. Does employee want to see a physician?

This must be checked for each accident report. Please check if employee wishes to see a physician.

8. Signature of supervisor/investigator and date.

These must be included for each accident report.

9. Manager's review, approval and date.

These are required. If the manager has a difference of opinion, that opinion should be noted on an attached sheet of paper and a copy stapled to each of the report's copies (white, yellow and pink).

10. Forward to:

Intercare Holdings Insurance Services (white original)  
Employer (yellow copy)  
Employee (pink copy)



INTERCARE HOLDINGS INSURANCE SERVICES  
P.O. Box 579 ROSEVILLE, CA 95661



### Supervisor's Investigation Report of Employee Accident *(To be completed by supervisor/investigator)*

1. Employee Name \_\_\_\_\_ Facility \_\_\_\_\_  
 Position \_\_\_\_\_ Department \_\_\_\_\_ Date of Hire \_\_\_\_\_  
 Date of Injury \_\_\_\_\_ Time of Injury \_\_\_\_\_ Date Reported \_\_\_\_\_
2. Describe injury and first-aid treatment \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
3. Describe the accident thoroughly, (what happened; i.e., location of accident, actions, tools conditions)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
4. Immediate cause of injury (indicate both activity and condition) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
5. Other contributing causes (please see instruction)
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_
6. Thoroughly describe all actions taken to correct accident causes listed above.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
7. What follow-up actions will be taken to prevent another occurrence?  
 \_\_\_\_\_
- 7a. Does employee want to see a physician? Yes \_\_\_\_\_ No \_\_\_\_\_
8. Signature of supervisor/investigator \_\_\_\_\_ Date \_\_\_\_\_
9. Manager's review and approval \_\_\_\_\_ Date \_\_\_\_\_

State of California <b>EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS</b>		Please complete in triplicate (type if possible) Mail two copies to:		OSHA CASE NO.	
				FATALITY <input type="checkbox"/>	
Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.		California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.			
EMPLOYER	1. FIRM NAME		1a. Policy Number		Please do not use this column
	2. MAILING ADDRESS: (Number, Street, City, Zip)		2a. Phone Number		CASE NUMBER
	3. LOCATION If different from Mailing Address (Number, Street, City and Zip)		3a. Location Code		OWNERSHIP
	4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.		5. State unemployment insurance acct no		
	6. TYPE OF EMPLOYER: <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> School District <input type="checkbox"/> Other Gov't, Specify: _____				INDUSTRY
	7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)		8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM		10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. DATE LAST WORKED (mm/dd/yy)		13. DATE RETURNED TO WORK (mm/dd/yy)	
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. SALARY BEING CONTINUED? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. DATE OF EMPLOYER'S KNOWLEDGE / NOTICE OF INJURY/ILLNESS (mm/dd/yy)	
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)		18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)		14. IF STILL OFF WORK, CHECK THIS BOX: <input type="checkbox"/>	
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning				SEX	
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)		20a. COUNTY		21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No	
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.		23. Other Workers Injured or ill in this event? <input type="checkbox"/> Yes <input type="checkbox"/> No		DAILY HOURS	
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold				DAYS PER WEEK	
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.				WEEKLY HOURS	
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY				WEEKLY WAGE	
27. Name and address of physician (number, street, city, zip)		27a. Phone Number		COUNTY	
28. Hospitalized as an inpatient overnight? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes then, name and address of hospital (number, street, city, zip)		28a. Phone Number		NATURE OF INJURY	
		29. Employee treated in emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No		PART OF BODY	
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. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.36(b)(2)(E)2. Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.36(b)(2)(E)2*.				SOURCE	
30. EMPLOYEE NAME		31. SOCIAL SECURITY NUMBER		32. DATE OF BIRTH (mm/dd/yy)	
33. HOME ADDRESS (Number, Street, City, Zip)				EVENT	
34. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)		33a. PHONE NUMBER	
36. DATE OF HIRE (mm/dd/yy)		37a. EMPLOYMENT STATUS <input type="checkbox"/> regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		SECONDARY SOURCE	
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours		37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED		EXTENT OF INJURY	
38. GROSS WAGES/SALARY \$ _____ per _____		39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Completed By (type or print)		Signature & Title		Date (mm/dd/yy)	
* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.36), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.					