## **Employer Accident Investigation Report**



## COMPLETE AND FAX OR EMAIL THIS REPORT WITHIN 24 HOURS FROM THE TIME OF ACCIDENT.

1111 W Long Lake Road, Suite 104, Troy, MI 48098 | Toll Free (888) 736-9071

The clients designated supervisor must notify Human Capital (on this form) of every injury or disease suffered by an employee, arising out of and in the course of employment.

Please fill out this form by clicking on the fields and typing the appropriate information on each line.

Please complete this form as soon as I	possible after an incident that re	esults in serious injury or illness occurs.	
(Optional: Use to investigate a minor injur	y or near miss that could have res	sulted in a serious injury or illness.)	
This is a report of a: Death	Lost Time	Dr. Visit Only First Aid Only Near Miss	è
Date of Incident:			
Employee			
Last Name:	First Name:	M.I. SSN:	
Street Address:		Apt:	
City:	State:	Zip:	
Phone Number:	Date of Birth:	Department:	
History of Claims			
Does Employee have any previous Wor		Yes	
If "Yes", please provide details below suc	h as date of claim and type of inju	ıry.	
Employer			
Current Employer: Human Capital			
Company Name:	Date of	f Hire:	
Company			
Office Address:	Suite:	City: State: Zip:	
Phone:	Fax:	Nature of Business:	
Step 1: Describe the Incident			
Date of Injury:	Hour of Injury:	AM PM	
What part of employee's workday:	Entering or leaving work	Doing normal work activities	
During break	Doing normal work activities	During meal period	
Working overtime	Other:		
Date Employer Notified:	Injury Reported To:		
Last Day Worked:	Date Returned to Work:	Class Code:	
<b>Employees Occupation (Job Title) Whe</b>	n Injured:	Department:	
Can a light duty position be accomoda	ted?	No Yes	
Is the employee an officer, partner or re	elative of the employer?	No Yes	
Nature of Injury:	Part of Body Injured:	On Company Premises? No Yes	
Was claimaint working at your company	y's client location?	No Yes	
Date of Assignment:			
Name/Address/Location of Accident:			
Job Assignment:			

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Was the employee paid for the day of in	njury?			No		Yes			
Time Employee Began Work:	AM PM								
Did the employee lose at least one full	day of work after the in	jury?		No		Yes			
Hospital or Clinic Name:			Ph	Phone:					
City:	State:		Zip	):					
If Validity of Claim is Doubted, State Re	eason:								
Was the injury caused by someone else	?			No		Yes	Name:		
Was the Employee Visibly injured?				No		Yes			
Was Employee noticeably confused?				No		Yes			
Did Employee appear intoxicated?				No		Yes			
Has employee recently been disciplined?				No		Yes			
If another person not employed by the Employer caused the Accident, give name and address:									
Name of Witness(es) if any:									
Number of attachments: Writter	witness statements:		Phot	ograph	s:		Maps/drav	wings:	
What personal protective equipment w	as being used (if any)?								
Describe, step-by-step the events that other important details)	led up to the injury: (Inc	clude names	of any	machi	nes,	parts, obj	ects, tools,	materials, and	
Please include any a	dditional comments y	ou feel are	e imp	ortant	on	a separa	te page.		
Step 2: Why did the incident happen?		ou feel are	e imp	ortant	on	a separa	te page.		
		you feel are Unsafe act							
Step 2: Why did the incident happen?			ts by p	eople:	(Ch	eck all tha			
Step 2: Why did the incident happen?  Unsafe workplace conditions: (Check a		Unsafe act	ts by p	<b>eople:</b> hout pe	(Ch	eck all tha			
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**Step 1: Describe the Incident** 



Step 3: How can future incidents be preven	ented?				
What changes:					
Stop this activity	Guard the hazard		Train the employee(s)		
Train the supervisor(s)	Redesign task ste	eps	Redesign work station		
Write a new policy/rule	Enforce existing p	oolicy	Routinely inspect for the hazard		
Personal Protective Equipment Other:					
What should be (or has been) done to car	rry out the suggestion	n(s) checked above?			
Step 4: Who completed and reviewed this form? (Please Print)					
Written by:		Title:			
Department:		Date:			
Names of investigation team members:					
Reviewed by:		Title:			
		Date:			

## Witness Statement

Canaval Information	
General Information	Employee Manage
Name of Injured Employee:	Employers Name:
Name of Witness:	Supervisor Name:
Position:	Street Address:
City/State/Zip:	
Phone Number:	
Location Where Incident Occurred:	
Date of Incident:	Time of Incident:
What were you (the witness) doing at the time of the incident?	
How and when did you become aware of the incident?	
What did you hear at the time of the incident?	
Who else was present?	
I, the undersigned, make the following statement, voluntary, withou I have read my statement as documented above and to the best of	
Signature	Date