Employer Accident Investigation Report

HUMAN CAPITAL
A Vensure Employer Services Company

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 possible after an incident that results in serious injury or illness occurs.
(Optional: Use to investigate a minor injury or near miss that could have resulted in a serious injury or illness.)

This is a report of a:	☐ Death	☐ Lost Time	☐ Dr. Visit Only	☐ First Aid Only	☐ Near Miss
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 Work Comp Claims? ☐ No ☐ Yes

If "Yes", please provide details below such as date of claim and type of injury.

Employer

Current Employer: Human Capital

Company Name:	**Date of 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:**		
Employees Occupation (Job Title) When Injured:		**Department:**		
Can a light duty position be accomodated?		☐ No ☐ Yes		
Is the employee an officer, partner or relative of the employer?		☐ No ☐ Yes		
Nature of Injury:	**Part of Body Injured:**	**On Company Premises?**	☐ No	☐ Yes
Was claimaint working at your company's client location?		☐ No ☐ Yes		
Date of Assignment:				
Name/Address/Location of Accident:				
Job Assignment:				

Step 1: Describe the Incident			
Was the employee paid for the day of injury?		☐ No ☐ Yes	
Time Employee Began Work:	☐ AM ☐ PM		
Did the employee lose at least one full day of work after the injury?		☐ No ☐ Yes	
Hospital or Clinic Name:		Phone:	
City:	**State:**	**Zip:**	
If Validity of Claim is Doubted, State Reason:			
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: **Written witness statements:** **Photographs:** **Maps/drawings:**

What personal protective equipment was being used (if any)?

Describe, step-by-step the events that led up to the injury: (Include names of any machines, parts, objects, tools, materials, and other important details)

Please include any additional comments you feel are important on a separate page.

Step 2: Why did the incident happen?	
Unsafe workplace conditions: (Check all that apply)	**Unsafe acts by people:** (Check all that apply)
☐ Inadequate guard	☐ Operating without permission
☐ Unguarded hazard	☐ Operating at unsafe speed
☐ Safety device is defective	☐ Servicing equipment that has power to it
☐ Tool or equipment defective	☐ Making a safety device inoperative
☐ Workstation layout is hazardous	☐ Using defective equipment
☐ Unsafe lighting	☐ Unsafe lifting by hand
☐ Unsafe ventilation	☐ Taking an unsafe position or posture
☐ Lack of needed personal protective equipment	☐ Distraction, teasing, horseplay
☐ Lack of appropriate equipment/tools	☐ Failure to wear personal protective equipment
☐ Unsafe clothing	☐ Failure to use the available equipment/tools
☐ Other:	☐ Other:

Did the accident involve employees or equipment from any other company? ☐ No ☐ Yes

Why did the unsafe conditions exist?

Why did the unsafe acts occur?

Was there a basis (such as "the job can be done more quickly" or "the product is less likely to be damaged") that may have encouraged the unsafe conditions or acts? ☐ No ☐ Yes

Where the unsafe acts or conditions reported prior to the incident? ☐ No ☐ Yes

Have there been similar incidents or near misses prior to this one? ☐ No ☐ Yes

Step 3: How can future incidents be prevented?		
What changes:		
☐ Stop this activity	☐ Guard the hazard	☐ Train the employee(s)
☐ Train the supervisor(s)	☐ Redesign task steps	☐ Redesign work station
☐ Write a new policy/rule	☐ Enforce existing policy	☐ Routinely inspect for the hazard
☐ Personal Protective Equipment	☐ Other:	

What should be (or has been) done to carry out the suggestion(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

General Information	
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?	
Describe what you saw at the time of the incident:	

I, the undersigned, make the following statement, voluntary, without threat, or promise of reward:
I have read my statement as documented above and to the best of my knowledge and belief, it is true and correct.

Signature

Date