Accident Fund
INSURANCE COMPANY OF AMERICA

Employee Accident Investigation Report

This form is to be completed by the injured employee and the supervisor in charge at the time of the accident.

FACILITY

NAME	CITY	STATE	LOCATION #

EMPLOYEE

NAME	SEX	D.O.B.	HEIGHT	WEIGHT
		/ /		

SOCIAL SECURITY #	HIRE DATE	FULL TIME	PART TIME	SHIFT: DAY	EVENING	NIGHT
— —	/ /	☐	☐	☐	☐	☐

DEPARTMENT	ADDRESS

JOB CLASSIFICATION	CITY, STATE	HOME PHONE #
		( )

DESCRIPTION OF ACCIDENT

ACCIDENT DATE	ACCIDENT TIME	ACCIDENT LOCATION
/ /	: a.m. ☐ p.m. ☐	

Please describe the accident, including what employee was doing when it occurred.

Name object or substance that directly attributed to the accident.

What caused the accident? How could it have been prevented?

Describe the injury.

BODY PART

☐ 1. Abdomen	☐ 13. Forearm(s)	☐ 25. Ribs	
☐ 2. Ankle(s)	☐ 14. Groin	☐ 26. Shoulder(s)	
☐ 3. Back	☐ 15. Hand(s)	☐ 27. Spine	
☐ 4. Buttock(s)	☐ 16. Head	☐ 28. Stomach	
☐ 5. Calf(s)	☐ 17. Hip(s)	☐ 29. Teeth	
☐ 6. Chest	☐ 18. Jaw	☐ 30. Thigh(s)	
☐ 7. Ear(s)	☐ 19. Knee(s)	☐ 31. Throat	
☐ 8. Elbow(s)	☐ 20. Leg(s)	☐ 32. Thumb(s)	
☐ 9. Eye(s)	☐ 21. Lungs	☐ 33. Toe	
☐ 10. Face	☐ 22. Mouth	☐ 34. Upper Arm(s)	
☐ 11. Finger(s)	☐ 23. Neck	☐ 35. Whole Body	
☐ 12. Foot	☐ 24. Nose	☐ 36. Wrist(s)	

TYPE OF CONDITION

☐ 1. Abrasion	☐ 13. Grinding Wound	☐ 25. Repetitive Motion Disorder	
☐ 2. Amputation	☐ 14. Hearing Loss	☐ 26. Scratch	
☐ 3. Avulsion	☐ 15. Heart Attach	☐ 27. Sliver	
☐ 4. Blister	☐ 16. Heat (cramps, stroke)	☐ 28. Splinter	
☐ 5. Burn	☐ 17. Hernia	☐ 29. Sprain/Strain	
☐ 6. Contusion	☐ 18. Infection	☐ 30. Slip/Fall	
☐ 7. Death	☐ 19. Insect Bite	☐ 31. Other _____	
☐ 8. Dermatitis	☐ 20. Irritation (dust)	_____	
☐ 9. Foreign Object	☐ 21. Irritation (vapor)	_____	
☐ 10. Fracture	☐ 22. Laceration		
☐ 11. Frostbite	☐ 23. Pulmonary Condition		
☐ 12. Ganglion	☐ 24. Puncture Wound		

Corrective actions taken to prevent reoccurrence.

Treatment

- ☐ *First Aid*
- ☐ *Panel of Physicians*
- ☐ *Emergency Room*
- ☐ *Personal Physician/Clinic*
- ☐ *Refused Treatment*
- ☐ *Other (name)* _____

Lost Time? ☐ Yes ☐ No	*Number of Days:*	*Modified/Restricted Duty* ☐ Yes ☐ No	NUMBER OF DAYS

Did employee accept medical treatment? ☐ Yes ☐ No	*Was employee hospitalized?* ☐ Yes ☐ No	*Did employee return to work the same day?* ☐ Yes ☐ No

Report Date / /	**Employee Signature**	**Supervisor Signature**