Supervisors Accident Investigation Report - Injured Worker

Employer: ______________________________ Employee #: ________________ Project #: __________

Address: _____________________________________ Name of Injured Worker: __________________

Constructor/GC : ______________________________ Address of Injured: ________________________

Address: _____________________________________

Date of Accident: ___________ Time of Accident: ____________ Accident Location: ________________

Birthdate: _________________ SIN # of Injured: _______________ Phone # of Injured: ______________

Supervisor on Site: ___________________ 1st Person Notified of Accident on Site: ________________

Date & Time Accident Reported: _________________ Office Notified? Yes No Time: ___________

Site Conditions: (Weather, Housekeeping, Lighting) ____

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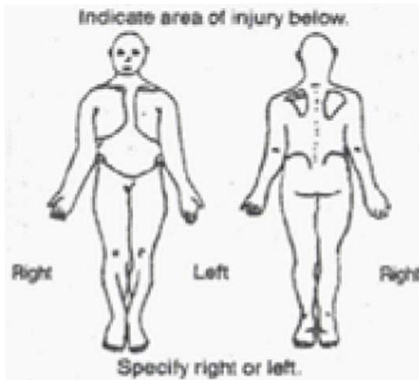
Circle Areas Worker Injured Below:



Sketch Workplace Area Below - Mark Location of Accident

Describe the Accident: Detail all equipment, objects, condition of tools, events, and circumstances that led to the accident. Indicate property damage, size and weight of equipment or material involved, person in most control of object, equipment or substance at the time. Indicate position of witnesses. Obtain measurements and measure distances.

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Nature of the Injury: (Describe injuries - Ex. Cuts, lacerations, bruises, pained areas, blood loss, etc.)

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Lost Time Injury Information Only:

How long Will Worker Be Off Work For: ______________________ Date & Hour Last Worked: ____________________

Normal Working Hours in Week: (Include OT if regular work includes standard OT Hours) ________________________

Start & Finish Time of Shift: ________________ Was Anyone Else Directly Involved in the Accident (Third Parties) ________

If so, detail actions, give addresses & phone numbers.

Names, Addresses & Phone Numbers of Witnesses or Workers in the area at the time of the Accident:

1.
2.
3.

Was a treatment memorandum issued to the injured worker? _______ **Did the worker sign it?** **Yes** **No**

Name, Address, & Phone Number of attending Physician, Surgeon or Clinic: (Is this the Family Doctor?)

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Did you accompany injured worker to Medical Treatment? _____ **Name of Escort:** _____________ **Approved to return to work?** _____

Any other vital details not listed before: ____

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Date & Time Reported to Ministry of Labour (if required): ______________________ **Name of MOL Rep:** ___________________

List PPE Used by Worker on Site: ____

What other protective equipment should have been used on site (if any): ______________________________

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What Actions have been taken to ensure that this incident is not repeated in the future?:

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Has the employee had a previous similar disability?: _____ **If yes, when?:** ________________________________

Did the employee collect Compensation as a result?: Yes No Name of Employer at the time: ____________________

Was there any serious or willful misconduct involved? Neglecting to follow Company Safety Rules or report the accident immediately?

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Are there any underlying pre-existing health conditions which could have played a part in the accident or aggravate the duration of disability? ____

____

Do you feel the need to investigate this claim further?: Yes No If so, please explain why: ________________________

____

Was this report completed with the injured worker present?: Yes No If not, please explain why: ____________________

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Was the investigation of this claim conducted immediately?: Yes No If not, Date and Time Conducted: ________________

Name of Person Who Conducted Investigation: ____________________ **Name of Foreman:** ____________________________

____________________	____________________	________________
Superintendent	**Foreman**	**Date**
____________________	____________________	
Employee	**Health & Safety Manager**	