

**Department of Military Affairs
Employee Accident Report and Investigation**

Part I: Injured Employee Information

Date of Hire: _____ **Job Title:** _____

Name of Employee (Last, First Middle):	Phone Number: (H): (W): (C):	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	Date of Birth:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed # of dependent children: _____
	Social Security Number:	
City/County and Zip Code where the accident Occurred:	Date of Injury:	Hour of injury: _____ AM/PM
	Time Work Began: _____ AM/PM	
Date/injury or illness reported:	Person to whom reported:	Name of witness:
Employee's Description of Accident (i.e. Describe machine, tool, or object causing injury or illness and describe fully how the incident occurred): 		
Injury Information (i.e. description of injury (burn, bruise, etc.): 		
I certify that the information provided above is true and complete. Employee Signature:		Date:

Part II: Supervisor's Investigation of the Incident:

Describe any UNSAFE Acts:
Describe any UNSAFE Conditions:
Identify the Cause(s) of the Accident:
Corrective Action Taken:

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Has it been done? If not, give reason.	
Was the accident/injury suspicious in nature? If so, please describe.	
Was the Panel of Physician's List Provided to the Employee? <input type="checkbox"/> Yes- Attach a copy to this report <input type="checkbox"/> No (explain why)	
I certify that the information provided above is true and complete. Supervisor's Signature:	Date:

Part III: Accident Analysis Details:

Severity of Injury/Damage:

- Fatality
 Lost Workdays
 Medical Treatment (off premises)
 First Aid (On site)
 Significant Property Damage

Employment Category:

- Regular, Full-time
 Regular, Part-time
 Temporary
 Contractor
 Other: _____

Time in Occupation at the time of the accident:

- Less than 6 months
 6 months to 2 years
 2 to 5 years
 More than 5 years

Work Shift at the time of the accident:

- Day Shift
 Evening Shift
 Night Shift

Prepared by: (Name & Title)	Work Phone #:	Date Report Prepared:
Reviewed by: (Name & Title)	Work Phone #:	Date Report Reviewed:

Follow – up Action:
