Department of Military Affairs
Employee Accident Report and Investigation

Part I: Injured Employee Information

Date of Hire: June 25, 2014 **Job Title: Administrative and Office Specialist**

Name of Employee (Last, First Middle): **Smith, Jane E**	**Phone Number: (H): 123-456-7890** **(W): 098-765-4321** **(C): 123-456-7891**	**Sex**: ☐ Male ☒ Female
Address: **12345 Mulberry Lane** **Mulberry, VA 12354**	**Date of Birth:** **01/02/1970** **Social Security Number:** **111-22-2359**	**Marital Status**: ☐ Single ☒ Married ☐ Divorced ☐ Widowed **# of dependent children**: _____2_____
City/County and Zip Code where the accident Occurred: **Blackstone, VA 23824**	**Date of Injury: 01/03/2015** **Time Work Began:** **07:00 AM**	**Hour of injury:** 11:00 AM
Date/injury or illness reported: **01/03/2015**	**Person to whom reported:** **SFC John Smith**	**Name of witness:** **None**
Employee's Description of Accident (i.e. Describe machine, tool, or object causing injury or illness and describe fully how the incident occurred): **On the above date and time, I was walking to my vehicle and slipped and fell on the ice in the parking lot. The ice was not cleared from the entire parking area and was around my car. I injured my lower back and left leg.**		
Injury Information (i.e. description of injury (burn, bruise, etc.): Lower back contusion and left leg abrasion		
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: Parking lot was not cleared appropriately prior to employees reporting to work.
Describe any UNSAFE Conditions: Inclement weather creating adverse conditions for employees.
Identify the Cause(s) of the Accident: Parking lot was not cleared appropriately prior to employees reporting to work.
Corrective Action Taken: **Employee parking areas made priority of clearing list.** **Employees instructed to park in only clear areas. Signs will be posted designated clear/safe areas.**

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Has it been done? If not, give reason. **Yes**
Was the accident/injury suspicious in nature? If so, please describe. **No**
Was the Panel of Physician's List Provided to the Employee? ☒ Yes- Attach a copy to this report ☐ 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) John Smith, Shift Supervisor	Work Phone #: 789-564-2315	Date Report Prepared: 01/04/2015
Reviewed by: (Name & Title)	Work Phone #:	Date Report Reviewed:

Follow – up Action:

_____
_____
_____
_____
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