# Department of Military Affairs
# Employee Accident Report and Investigation

## Part I: Injured Employee Information

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

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|---|---|---|
| **Name of Employee (Last, First Middle):** | **Phone Number: (H):**<br>**(W):**<br>**(C):** | **Sex**:<br>☐ Male<br>☐ Female |
| **Address:** | **Date of Birth:**<br>**Social Security Number:** | **Marital Status**:<br>☐ Single<br>☐ Married<br>☐ Divorced<br>☐ Widowed<br>**# of dependent children**:<br>_____ |
| **City/County and Zip Code where the accident Occurred:** | **Date of Injury:**<br>**Time Work Began:** _____ PM | **Hour of injury:**<br>_____ 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.**<br>**Employee Signature:** | | **Date:** |

## Part II: Supervisor's Investigation of the Incident:

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| **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?** ☐ Yes- Attach a copy to this report ☐ No (explain why) | |
| **I certify that the information provided above is true and complete.**<br>**Supervisor's Signature:** | **Date:** |

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**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:**

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