

SUPERVISOR'S REPORT OF ACCIDENT - INTAKE FORM

EMPLOYEE NAME:		SOCIAL SECURITY #:		DATE OF INJURY:		LOCATION ACCIDENT OCCURRED:	
DESCRIPTION OF INJURY:							
HOME ADDRESS:			TOWN/STATE:	ZIP CODE:	TELE #:	# DEPENDENTS:	DATE OF HIRE:
MARITAL STATUS:	SEX (M or F)	DATE OF BIRTH:	OCCUPATION:		DEPARTMENT/SCHOOL:	WORK TELEPHONE	
WITNESS:			WITNESS ADDRESS/TELEPHONE #:			AVERAGE WEEKLY WAGE	
TO WHOM WAS INJURY REPORTED		THEIR POSITION		DID EMPLOYEE LOSE TIME FROM WORK?		WAS MEDICAL TREATMENT SOUGHT?	
MEDICAL FACILITY/DOCTOR:			DATE REPORTED AS WORK RELATED	BODY PART:	INJURY:	RETURN TO WORK DATE:	

*******Supervisor Must Complete Below*******

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED? WHY?	
CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY	
WAS EMPLOYEE WEARING SAFETY GEAR?	
YES/NO (If no, explain) _____	
ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS:	

REMARKS:	_____

Investigated by: _____ Date: _____

Reviewed by: _____ Date: _____

Supervisor

School Nurse

ACCIDENT INVESTIGATION REPORT

{Insert Member's Name}



Instructions: This does not replace the "101" First Report of Injury Form. Additionally, Supervisors will use this form to report all work-related injuries, illnesses, or "near miss" incidents - no matter the severity. This aids in the identification and correction of hazards and in the prevention of future similar type injuries from occurring. Pages 1, 2 and 4 are to be completed by Supervisors and Page 3 by both Supervisor and Injured Employee. All photos can be inserted as images on Page 4.

This is a report of a work-related: Injury Illness Near Miss Fatality

Employee Name:		Department:	
Supervisor's Name:		Department:	
Date of Occurrence:	Incident Time:	am/pm	Date Reported:

Injury Type (most serious)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Burn -heat/chemical | <input type="checkbox"/> Strain/Sprain | <input type="checkbox"/> Animal Bite/Sting | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Cut, laceration, puncture | <input type="checkbox"/> Broken Bone | <input type="checkbox"/> Skin irritation | <input type="checkbox"/> Concussion/Head Trauma |
| <input type="checkbox"/> Bruise/Contusion | <input type="checkbox"/> Inhalation | <input type="checkbox"/> Human Bite | <input type="checkbox"/> Amputation |
| <input type="checkbox"/> Needlestick | <input type="checkbox"/> Abrasion Scrape | <input type="checkbox"/> Bodily Reaction | <input type="checkbox"/> Hospitalization Admission |
| <input type="checkbox"/> Crushing Injury | <input type="checkbox"/> Eye Irritation/Cut/Scratch | <input type="checkbox"/> Illness | <input type="checkbox"/> Fatality |

Parts of Body Affected:

DESCRIPTION OF THE INCIDENT - (Where, What, Why, When, etc.)

Where, exactly, did the incident occur?

What was the injured employee doing at the time of the incident?

Describe, step-by-step, what led up to the incident (i.e., EE was pruning trees, while on ladder, slipped...

WITNESS INFORMATION - List the names, titles & Dept. of anyone witness to the incident.

Name	Title	Dept./Other/Phone#

Investigation report completed by:	_____	/ /
Employee's Supervisor	_____	/ /
Department Head	_____	/ /

ACCIDENT INVESTIGATION REPORT

CAUSES OF THE ACCIDENT - Supervisor Complete

Using the list below, please identify cause(s) or potential cause(s) that contributed to this incident. Check all that apply.

- | | | |
|--|--|---|
| <input type="checkbox"/> Improper instruction | <input type="checkbox"/> Failure to lockout | <input type="checkbox"/> Unsafe clothing |
| <input type="checkbox"/> Lack of training or skill | <input type="checkbox"/> Inadequate lighting | <input type="checkbox"/> Improper maintenance |
| <input type="checkbox"/> Operating without authority | <input type="checkbox"/> Inadequate ventilation | <input type="checkbox"/> Unsafe/Defective tool/eqpt |
| <input type="checkbox"/> Improper Storage of Chemicals | <input type="checkbox"/> Unsafe lifting | <input type="checkbox"/> Distraction |
| <input type="checkbox"/> Poor housekeeping | <input type="checkbox"/> Inoperative safety device | <input type="checkbox"/> Improper use of equipment |
| <input type="checkbox"/> Failure to use proper personal protective equipment | <input type="checkbox"/> Unsafe arrangement or process | |
| <input type="checkbox"/> Failure to use available tools/equipment | <input type="checkbox"/> Physical or mental impairment | |
| <input type="checkbox"/> Struck By Person | <input type="checkbox"/> Slip/Fall Same level | <input type="checkbox"/> Trip |
| <input type="checkbox"/> Struck By Object | <input type="checkbox"/> Slip/Fall from Height | <input type="checkbox"/> Slip/Wet or Icy Surface |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Caught/Between | <input type="checkbox"/> Vehcile Incident |

Was there a reward/incentive, supervisory order or time constraint? Yes No

If YES, explanation:

Were the unsafe acts or conditions reported prior to the incident? Yes No

Have there been similar incidents or near misses prior to this one? Yes No

If 'Yes' provide explanation:

ACCIDENT PREVENTION

What changes are recommended to prevent future occurrences of similar incidents?

- | | |
|---|---|
| <input type="checkbox"/> Stop this activity/task | <input type="checkbox"/> Enforce existing policy/procedure |
| <input type="checkbox"/> Redesign the activity/task | <input type="checkbox"/> Develop a new policy/procedure |
| <input type="checkbox"/> Redesign the workstation | <input type="checkbox"/> Additional personal protective equipment |
| <input type="checkbox"/> Train the employee(s) | <input type="checkbox"/> Additional oversight by supervisor(s) |
| <input type="checkbox"/> Train the supervisor(s) | <input type="checkbox"/> Routinely inspect for the hazard |
| <input type="checkbox"/> Other: | |

List below Recommendation for Prevention and Improvement

The following Corrective Action will be implemented with in ___ days or immediately if high hazard or life threatening.

What should be (or has been) done to facilitate the recommendations identified above?

ACCIDENT INVESTIGATION REPORT

EMPLOYEE'S STATEMENT

Employee needs to complete this form with along with the Supervisor to aid in the identification of hazards, deduce a corrective action and sign-off on corrective action completion.

Date of incident? _____ Where, exactly, did the incident occur

Describe Step-By-Step, what led up to the incident; and include if Proper Protective Equipment was being worn or provided:

What/How do you feel this could have prevented this incident/injury?

Was proper training provided?

Please provide corrective action or suggestion for preventing future similar type incidents:

Employee's Signature

Name _____

Date _____

Supervisor's Signature

Name _____

Date _____

ACCIDENT INVESTIGATION REPORT

Insert Photos below (choose Insert/picture/select "File name"):

1. Describe photo



Massachusetts
Based
Member
Driven

MIA Member Services
One Federal Street, Ste. 19
Boston, Massachusetts 02110
Toll Free (Mass) Tel: 888-266-6442
Fax: 617-753-9987

MEDICAL AUTHORIZATION

To: _____

Date: _____

and any other physician, hospital, clinic or medical care provider, presently unknown to me, who may have or subsequently acquire information concerning my physical condition. You are hereby authorized to give Aon Risk Services of Massachusetts and the Corvel Corporation (or any of its representative), all information, facts and particulars, including reports, records, results from diagnostic tests, X-rays and statement of charges which may be requested regarding my medical condition, diagnosis, treatment and to furnish them copies of such reports. You are further authorized to allow any physicians appointed by them to review all such reports, records and X-rays in your possession.

I am willing that a photo static copy of this authorization be accepted with the same authority as the original.

This information is to be used for handling my claim from an occupational injury or illness occurring on or about _____ and for no other purpose, now or in the future.

This authorization is valid for the duration of the above condition.

Employee's Signature

Date

Employer: _____

Name of Employee: _____

SS#: _____

Date of Birth: _____

Claim #: _____

Date of Accident: _____

