

## K.A.S.B. Workers Compensation Fund, Inc. Supervisor's Accident Investigation Report

*This report is to be filled out as soon as the accident is reported by the injured person. This form and the "EMPLOYER'S REPORT OF ACCIDENT" form must be sent to the Safety Coordinator ASAP, and forwarded to KASB Workers Compensation Fund, Inc. claims department.*

Name of person injured: \_\_\_\_\_ Age: \_\_\_\_\_

Department: \_\_\_\_\_ Employment status:  Full-time  Part-time  Volunteer

Job Title: \_\_\_\_\_ Hours into shift: \_\_\_\_\_ How long employed: \_\_\_\_\_

Date of accident/injury: \_\_\_\_\_ Time of accident/injury: \_\_\_\_\_ a.m./p.m. Date reported: \_\_\_\_\_

Type of injury/illness: \_\_\_\_\_ Body part affected: \_\_\_\_\_

Exact location of accident: \_\_\_\_\_

Specific activity when accident occurred: \_\_\_\_\_ Was Accident site reviewed by supervisor?  Yes  No

Did supervisor interview injured person?  Yes  No Did supervisor interview eyewitnesses?  Yes  No

Exactly how did accident occur? Describe persons, action, equipment, conditions, etc. \_\_\_\_\_

Was employee using required safety equipment, materials, or chemicals?  Yes  No  N/A

What could have been utilized to prevent this accident? \_\_\_\_\_ Is it available?  Yes  No

Training: \_\_\_\_\_

Communications: \_\_\_\_\_

Policies/procedures: \_\_\_\_\_

Inspections: \_\_\_\_\_

**Supervisor's Accident Investigation Report: (Continued)**

Report by injured employee attached?  Yes No

Reports of eyewitnesses attached? Yes  No

Was first aid administered on the scene?  Yes No

Was employee taken to the hospital/clinic?  Yes No

If so, by whom? \_\_\_\_\_

Do you expect this to be a lost time accident?  Yes No

What immediate action has been taken to prevent occurrence of a similar accident? \_\_\_\_\_

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**Upon completion of this investigation, sign and turn in to the person in your facility who is responsible for filing Workers compensation claims.**

\_\_\_\_\_  
Supervisor signature

\_\_\_\_\_  
Date

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\*

**ROUTING**

Department Head (if different than supervisor) comments: \_\_\_\_\_

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\_\_\_\_\_  
Department Head signature

\_\_\_\_\_  
Date

### REPORT BY INJURED EMPLOYEE

Employer: \_\_\_\_\_

Your Name: \_\_\_\_\_

Your Home Address: \_\_\_\_\_

Your Home Phone Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Weekly Wage: \_\_\_\_\_

In your own words, please describe what happened: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What physical problems do you relate to this injury?

\_\_\_\_\_

\_\_\_\_\_

Did you report this injury to your supervisor? \_\_\_\_\_ If not, why not? \_\_\_\_\_

Date Reported? \_\_\_\_\_ Supervisor's Name: \_\_\_\_\_

Were you working at your regular job at the time of the injury? \_\_\_\_\_ If not, please explain:

\_\_\_\_\_

\_\_\_\_\_

Were there any witnesses? \_\_\_\_\_ If yes, who? \_\_\_\_\_

\_\_\_\_\_

Did you go to a hospital/clinic? Yes \_\_\_\_\_ No \_\_\_\_\_

Address of hospital/clinic: \_\_\_\_\_

Name of treating physician: \_\_\_\_\_

Any additional comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Date

\_\_\_\_\_ Signature

## REPORT BY EYEWITNESS

Name: \_\_\_\_\_

Name of Injured Employee: \_\_\_\_\_

Name of Witness: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Date of Incident: \_\_\_\_\_

In your own words, describe what you saw happen: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did anyone else see the accident?  Yes  No

If yes, please list their name(s)? \_\_\_\_\_

\_\_\_\_\_

Other comments: \_\_\_\_\_

\_\_\_\_\_

Signature of Eyewitness: \_\_\_\_\_