WORKNET INCIDENT INVESTIGATION REPORT

PLEASE FAX THIS REPORT TO THE INSURANCE DEPT. WITHIN 4 HOURS OF ACCIDENT

CLIENT ______________________ **CLIENT #** _________ **WC CODE** ☐☐☐☐ F ☐

INJURED EMPLOYEE

Name of Injured Employee ____

Address ____

Social Security ☐☐☐-☐☐-☐☐☐☐ Date Hired ☐☐-☐☐-☐

Phone ☐☐☐-☐☐☐-☐☐☐☐ Hourly Wage $☐☐.☐☐

Date of Birth ____/____/____ Marital Status _______ # Dependents __________ ________

Occupation ___________________________ Reg. Work Days & Hours ______________________

INCIDENT INFORMATION

Date of Incident ____/____/____ Time ___:____ ____M Reported Immediately ? ______

Injury Type ___________________________________ RTW Date ________________

Description of Incident

____

____

Client Name ____ Client # ________________

Contact ____________________________________ Telephone # ________________________

Did accident occur on Client premises? ☐Yes ☐No

Location of Incident ____

☐ Police Report ? ☐ OSHA Report? ☐ EPA Report? ☐ Fire Report? ☐ Report # ____________

(check Any that apply)

Third Party Information

Person/Equipment/ Device that contributed to incident

____

____ Witnesses *

____

Name & Address of Physician ____

Name & Address of Hospital ____

CORRECTIVE ACTION Needed To Prevent Reoccurrence of Claim ?

Unsafe Act? ☐ **No** ☐ **Yes** If **"YES"** specify action taken:

____

____

SIGNATURES

Injured employee Signature ___________________________________ Date __________

RD#☐☐☐☐ Preparer _____________________________________ Date __________

*** Complete and attach "Incident Investigation Witness/Supervisor Statement" found in Kit**

WITNESS/SUPERVISOR STATEMENT

Injured Employee ______________________ Client Location ______________

Witness/Supervisor ______________________ TEL # ______________

INCIDENT INFORMATION

Date of Incident ☐☐-☐☐-☐☐ Time ☐☐:☐☐ ☐M

Did you see the incident occur? ☐YES ☐NO

If **"YES"** please describe Incident / If **"NO"** how did you learn of it?:

____

____

____

Was anyone injured due to this incident? **☐NO ☐YES** (WHO) ______________

If **"YES"** describe Injury ______________________

Was employee using a tool, device, or machine, or driving a car at time of incident? **☐NO ☐YES**

If **"YES"** provide specific information: ______________________

____

Have others been injured in the same way? **☐NO ☐YES (WHEN)** ______________

Was this employee instructed in safety procedures? **☐YES ☐NO**

Did this employee violate safety procedures? **☐NO ☐YES** If **"YES"** list Violations ______________

____

____

Has this employee ever mentioned any prior injuries or similar injuries or condition? **☐NO ☐YES**

If **"YES"** please describe______________________

Check those factors which you believe contributed to the cause of the incident:

☐Equipment Usage or Condition ☐Horseplay ☐ A Third Party ______________

☐Poor Training ☐ Equipment Failure

☐Lack of Safety Devices ☐ Carelessness ☐ Other ______________

SIGNATURES

Witness/Supervisor ______________________ Date ______________

RD# ☐☐☐☐ Preparer ______________________ Date ______________

To the best of my knowledge I have answered all of the above questions truthfully.