# 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 Number ____________________________________ Date Hired ________________

Phone ____________________________ Alt # _________________________ Hourly Wage $____________

Date of Birth _________________________ Marital Status __________ # Dependents ____________________

Occupation _______________________________________ Reg. Work Days & Hours _____________________

***INCIDENT INFORMATION***

Date of Incident _____________ Time ____________ ____M Reported Immediatelty? ________

Injury Type __________________________________________ RTW Date ______________________

Description of Incident

_____________________________________________________________________________________

_____________________________________________________________________________________

Client Name ________________________________________ Client # ______________________________

Contact: ________________________________________ Telephone # ______________________________

Did accident occur on Client premises? ☐ Yes ☐ No

☐ 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 Reoccurence 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 it Kit.**

***Additional Notes:***

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

# WITNESS / SUPERVISOR STATEMENT

Injured Employee ____________________________________________ Client Location __________________

Witness / Supervisor ____________________________________________ TEL# __________________________

## *INCIDENT INFORMATION*

Date of Incident _____________________________ Time: ____:_______ AM / PM

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**" Provide specific information: ____________________________________________________________

_____________________________________________________________________________________________

Have others been injured n the same way? ☐ **NO** ☐ **YES** **(WHEN)** _____________________________

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

Did this employee violate safety provedures? ☐ **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 causes of the Incident

☐ Equipmemt Usage or Condition ☐ Horseplay ☐ A Third Party ________________

☐ Poor Training ☐ Equipment Failure

☐ Lack of Safety Devices ☐ Carelessness ☐ Other _______________________

## *SIGNATURES*

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

Witness / Supervisor Statement _________________________________________ Date ___________________

RD# ☐☐☐☐ Preparer ____________________________________ **Date** ____________________