

# Employer Accident Investigation Report

**COMPLETE AND FAX OR EMAIL THIS REPORT WITHIN 24 HOURS FROM THE TIME OF ACCIDENT.**

For questions completing this form, call Toll Free 800-845-5695 | Fax 480-289-6220 | WCNewClaims@Hapeo.com

The clients designated supervisor must notify Harbor America (on this form) of every injury or disease suffered by an employee, arising out of and in the course of employment.

**Please fill out this form by clicking on the fields and typing the appropriate information on each line.**

**Please complete this form as soon as possible after an incident that results in serious injury or illness occurs.**

(Optional: Use to investigate a minor injury or near miss that could have resulted in a serious injury or illness.)

**This is a report of a:**  Death  Lost Time  Dr. Visit Only  First Aid Only  Near Miss

**Date of Incident:**

## Employee

<b>Last Name:</b>	<b>First Name:</b>	<b>M.I.</b>	<b>SSN:</b>
<b>Street Address:</b>			<b>Apt:</b>
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
<b>Phone Number:</b>	<b>Date of Birth:</b>	<b>Department:</b>	

## History of Claims

**Does Employee have any previous Work Comp Claims?**  No  Yes

If "Yes", please provide details below such as date of claim and type of injury.

## Employer

**Current Employer:** Harbor America

**Company Name:** \_\_\_\_\_ **Date of Hire:** \_\_\_\_\_

## Company

<b>Office Address:</b>	<b>Suite:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Phone:</b>	<b>Fax:</b>	<b>Nature of Business:</b>		

## Step 1: Describe the Incident

<b>Date of Injury:</b>	<b>Hour of Injury:</b>	<input type="checkbox"/> AM <input type="checkbox"/> PM
<b>What part of employee's workday:</b>	<input type="checkbox"/> Entering or leaving work	<input type="checkbox"/> Doing normal work activities
<input type="checkbox"/> During break	<input type="checkbox"/> Doing normal work activities	<input type="checkbox"/> During meal period
<input type="checkbox"/> Working overtime	<input type="checkbox"/> Other:	
<b>Date Employer Notified:</b>	<b>Injury Reported To:</b>	
<b>Last Day Worked:</b>	<b>Date Returned to Work:</b>	<b>Class Code:</b>
<b>Employees Occupation (Job Title) When Injured:</b>		<b>Department:</b>
<b>Can a light duty position be accomodated?</b>		<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Is the employee an officer, partner or relative of the employer?</b>		<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Nature of Injury:</b>	<b>Part of Body Injured:</b>	<b>On Company Premises?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Was claimaint working at your company's client location?</b>		<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Date of Assignment:</b>		
<b>Name/Address/Location of Accident:</b>		
<b>Job Assignment:</b>		

### Step 1: Describe the Incident

Was the employee paid for the day of injury?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
Time Employee Began Work:	AM	PM	
Did the employee lose at least one full day of work after the injury?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hospital or Clinic Name:		Phone:	
City:	State:	Zip:	
If Validity of Claim is Doubted, State Reason:			
Was the injury caused by someone else?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
Was the Employee Visibly injured?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
Was Employee noticeably confused?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
Did Employee appear intoxicated?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
Has employee recently been disciplined?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
If another person not employed by the Employer caused the Accident, give name and address:			

Name of Witness(es) if any:			
Number of attachments:	Written witness statements:	Photographs:	Maps/drawings:
What personal protective equipment was being used (if any)?			

Describe, step-by-step the events that led up to the injury: (Include names of any machines, parts, objects, tools, materials, and other important details)

Please include any additional comments you feel are important on a separate page.

### Step 2: Why did the incident happen?

Unsafe workplace conditions: (Check all that apply)	Unsafe acts by people: (Check all that apply)
<input type="checkbox"/> Inadequate guard	<input type="checkbox"/> Operating without permission
<input type="checkbox"/> Unguarded hazard	<input type="checkbox"/> Operating at unsafe speed
<input type="checkbox"/> Safety device is defective	<input type="checkbox"/> Servicing equipment that has power to it
<input type="checkbox"/> Tool or equipment defective	<input type="checkbox"/> Making a safety device inoperative
<input type="checkbox"/> Workstation layout is hazardous	<input type="checkbox"/> Using defective equipment
<input type="checkbox"/> Unsafe lighting	<input type="checkbox"/> Unsafe lifting by hand
<input type="checkbox"/> Unsafe ventilation	<input type="checkbox"/> Taking an unsafe position or posture
<input type="checkbox"/> Lack of needed personal protective equipment	<input type="checkbox"/> Distraction, teasing, horseplay
<input type="checkbox"/> Lack of appropriate equipment/tools	<input type="checkbox"/> Failure to wear personal protective equipment
<input type="checkbox"/> Unsafe clothing	<input type="checkbox"/> Failure to use the available equipment/tools
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
Did the accident involve employees or equipment from any other company? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Why did the unsafe conditions exist?	
Why did the unsafe acts occur?	
Was there a basis (such as "the job can be done more quickly" or "the product is less likely to be damaged") that may have encouraged the unsafe conditions or acts? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Where the unsafe acts or conditions reported prior to the incident? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Have there been similar incidents or near misses prior to this one? <input type="checkbox"/> No <input type="checkbox"/> Yes	

**Step 3: How can future incidents be prevented?**

**What changes:**

<input type="checkbox"/> Stop this activity	<input type="checkbox"/> Guard the hazard	<input type="checkbox"/> Train the employee(s)
<input type="checkbox"/> Train the supervisor(s)	<input type="checkbox"/> Redesign task steps	<input type="checkbox"/> Redesign work station
<input type="checkbox"/> Write a new policy/rule	<input type="checkbox"/> Enforce existing policy	<input type="checkbox"/> Routinely inspect for the hazard
<input type="checkbox"/> Personal Protective Equipment	<input type="checkbox"/> Other:	

**What should be (or has been) done to carry out the suggestion(s) checked above?**

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**Step 4: Who completed and reviewed this form? (Please Print)**

<b>Written by:</b>	<b>Title:</b>
<b>Department:</b>	<b>Date:</b>
<b>Names of investigation team members:</b>	
<b>Reviewed by:</b>	<b>Title:</b>
	<b>Date:</b>

# Witness Statement

General Information	
Name of Injured Employee:	Employers Name:
Name of Witness:	Supervisor Name:
Position:	Street Address:
City/State/Zip:	
Phone Number:	
Location Where Incident Occurred:	
Date of Incident:	Time of Incident:
What were you (the witness) doing at the time of the incident?	
How and when did you become aware of the incident?	
What did you hear at the time of the incident?	
Who else was present?	
Describe what you saw at the time of the incident:	

I, the undersigned, make the following statement, voluntary, without threat, or promise of reward:  
I have read my statement as documented above and to the best of my knowledge and belief, it is true and correct.

Signature

Date