Chesapeake Employers Insurance
Your workers' compensation specialist

Supervisor's Accident Investigation Form

Policyholder: _____

Policy #: _____

(To be completed by the employee's supervisor or other responsible administrative official.)

Location where accident occurred:		Employer's Premises: Yes ☐ No ☐ Job site: Yes ☐ No ☐	Date of accident or illness:
Who was injured?		Employee ☐ Non-employee ☐ If non-employee, specify_____	Time of accident a.m. ☐ p.m. ☐
Length of time with firm:	Job title or occupation:	Name of dept. normally assigned to:	How long has employee worked at job where injury or illness occurred?
What property/equipment was damaged?			Property/equipment owned by:
What was employee doing when injury/illness occurred? What machine or tool was being used? What type of operation?			
How did injury/illness occur? List all objects and substances involved.			
Was the accident the result of another party's negligence? If so, name of the negligent party:			
Part of body affected/injured?		Any prior physical conditions? If so, what? Yes ☐ No ☐	
Nature and extent of injury/illness and property damaged (be specific):			
Do you have any concerns about this alleged accident or injury? If so, please specify:			

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

____ Failure to lockout	____ Improper maintenance	____ Poor housekeeping
____ Failure to secure	____ Improper protective equipment	____ Poor ventilation
____ Horseplay	____ Inoperative safety device	____ Unsafe arrangement or process
____ Improper dress	____ Lack of training or skill	____ Unsafe equipment
____ Improper guarding	____ Operating without authority	____ Unsafe position
____ Improper instruction	____ Physical or mental impairment	____ Other _____

Supervisor's corrective action to ensure this type of accident does not recur: _____

_____

_____

_____

Was employee trained in the appropriate use of Personal Protective Equipment/proper safety procedures? ...Yes ___ No ____

Was employee using the appropriate Personal Protective Equipment/proper safety procedures at the time?....Yes ___ No ____

Did employee promptly report the injury/illness? .....Yes ___ No ____

Is there modified duty available? .....Yes ___ No ____

Supervisor's name	Supervisor's signature	Phone #	Date
_____	_____	_____	_____