Accident Fund
INSURANCE COMPANY OF AMERICA

# Employee Accident Investigation Report

This form is to be completed by the injured employee and the supervisor in charge at the time of the accident.

## FACILITY

| NAME | CITY | STATE | LOCATION # |
|---|---|---|---|
| | | | |

## EMPLOYEE

| NAME | SEX | D.O.B. / / | HEIGHT | WEIGHT |
|---|---|---|---|---|
| | | | | |

| SOCIAL SECURITY # — — | HIRE DATE / / | FULL TIME ☐ PART TIME ☐ | SHIFT: DAY ☐ EVENING ☐ NIGHT ☐ |
|---|---|---|---|
| | | | |

| DEPARTMENT | ADDRESS | |
|---|---|---|
| | | |
| JOB CLASSIFICATION | CITY, STATE | HOME PHONE # ( ) |
| | | |

## DESCRIPTION OF ACCIDENT

| ACCIDENT DATE / / | ACCIDENT TIME : a.m. ☐ p.m. ☐ | ACCIDENT LOCATION |
|---|---|---|
| | | |

*Please describe the accident, including what employee was doing when it occurred.*

*Name object or substance that directly attributed to the accident.*

*What caused the accident? How could it have been prevented?*

*Describe the injury.*

**BODY PART**

| | | |
|---|---|---|
| ☐ 1. Abdomen | ☐ 13. Forearm(s) | ☐ 25. Ribs |
| ☐ 2. Ankle(s) | ☐ 14. Groin | ☐ 26. Shoulder(s) |
| ☐ 3. Back | ☐ 15. Hand(s) | ☐ 27. Spine |
| ☐ 4. Buttock(s) | ☐ 16. Head | ☐ 28. Stomach |
| ☐ 5. Calf(s) | ☐ 17. Hip(s) | ☐ 29. Teeth |
| ☐ 6. Chest | ☐ 18. Jaw | ☐ 30. Thigh(s) |
| ☐ 7. Ear(s) | ☐ 19. Knee(s) | ☐ 31. Throat |
| ☐ 8. Elbow(s) | ☐ 20. Leg(s) | ☐ 32. Thumb(s) |
| ☐ 9. Eye(s) | ☐ 21. Lungs | ☐ 33. Toe |
| ☐ 10. Face | ☐ 22. Mouth | ☐ 34. Upper Arm(s) |
| ☐ 11. Finger(s) | ☐ 23. Neck | ☐ 35. Whole Body |
| ☐ 12. Foot | ☐ 24. Nose | ☐ 36. Wrist(s) |

**TYPE OF CONDITION**

| | | |
|---|---|---|
| ☐ 1. Abrasion | ☐ 13. Grinding Wound | ☐ 25. Repetitive Motion Disorder |
| ☐ 2. Amputation | ☐ 14. Hearing Loss | ☐ 26. Scratch |
| ☐ 3. Avulsion | ☐ 15. Heart Attach | ☐ 27. Sliver |
| ☐ 4. Blister | ☐ 16. Heat (cramps, stroke) | ☐ 28. Splinter |
| ☐ 5. Burn | ☐ 17. Hernia | ☐ 29. Sprain/Strain |
| ☐ 6. Contusion | ☐ 18. Infection | ☐ 30. Slip/Fall |
| ☐ 7. Death | ☐ 19. Insect Bite | ☐ 31. Other _____ |
| ☐ 8. Dermatitis | ☐ 20. Irritation (dust) | |
| ☐ 9. Foreign Object | ☐ 21. Irritation (vapor) | |
| ☐ 10. Fracture | ☐ 22. Laceration | |
| ☐ 11. Frostbite | ☐ 23. Pulmonary Condition | |
| ☐ 12. Ganglion | ☐ 24. Puncture Wound | |

*Corrective actions taken to prevent reoccurrence.*

**Treatment**

- ☐ *First Aid*
- ☐ *Panel of Physicians*
- ☐ *Emergency Room*
- ☐ *Personal Physician/Clinic*
- ☐ *Refused Treatment*
- ☐ *Other (name)* _____

| **Lost Time?** ☐ Yes ☐ No | *Number of Days:* | *Modified/Restricted Duty* ☐ Yes ☐ No | NUMBER OF DAYS |
|---|---|---|---|
| | | | |

| *Did employee accept medical treatment?* ☐ Yes ☐ No | *Was employee hospitalized?* ☐ Yes ☐ No | *Did employee return to work the same day?* ☐ Yes ☐ No |
|---|---|---|
| | | |

| **Report Date** / / | **Employee Signature** | **Supervisor Signature** |
|---|---|---|
| | | |

LC-8 Rev. 11-02 **(THIS IS NOT A CLAIM FORM - TO BE USED ONLY FOR INTERNAL ACCIDENT PREVENTION PURPOSES)**