

Accident Investigation Forms

Need Help?

If you would like assistance in setting up supervisory training on how to use these forms, please contact your Chesapeake Employers Claims Adjuster or Safety Management Consultant at 1-800-264-4943.

Forms may be copied as needed. These forms are also available for printing in PDF format online at www.ceiwc.com/forms-and-publications or by scanning the QR code.



Accident investigation forms/statements **should be filled out by the injured employee, supervisor and any witness** to the accident. Train your supervisors to conduct the preliminary investigation as soon as possible.

IMPORTANT – Care must be taken to ensure the investigation is fact finding, not fault finding. Obtaining signed statements as soon as possible following an accident ensures that you, the employer, have an accurate account of how the injury occurred. These complete statements are important in helping to correct hazards and prevent the accident from recurring. They also help to spot possible third-party liability as well as possible fraudulent claims.

After I have completed these forms, what do I do with them?

Please send the completed forms to your Chesapeake Employers Claims Adjuster and keep a copy for your files. These completed forms can provide valuable information in a claims investigation of an injury and for developing the defense in the event of a workers' comp hearing.

What if my injured employee is physically unable to fill out an Employee's Report of Injury?

Use common sense and good judgement. If the injury is severe, remember, your employee's health and care are first and foremost. If possible, have the form filled out at a later, more appropriate time when the employee is physically able to document the accident.

What if my employee refuses to fill out or sign an Employee's Report of Injury?

You cannot require an employee to complete the document. You can, however, stress the importance of obtaining an account of the accident to set the record straight and help prevent the injury from happening again. Also, still obtain the supervisor's report as well as any witness statements.

What if my Employee has retained an attorney? Can I still ask the injured employee to fill out an Employee's Report of Injury?

Yes. You, the employer, as part of your company's accident management plan, can still ask the employee to fill out the report form.

Employee's Report of Injury

Policyholder: _____

Policy # _____

To be completed by the employee only.

Employee's name: _____ ☐ Male ☐ Female

Date of birth: ____/____/____ Last First Middle Email: _____ Cell Phone # (____) _____

Marital status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Height/Weight: _____ / _____ lbs. ☐ Right- or ☐ left-hand dominant

Home address: _____

City: _____ State: _____ Zip Code: _____

Current job position: _____ Date of Hire: _____

Employment Status: ☐ Full time ☐ Part time ☐ Volunteer SSN: _____ Weekly salary: _____

Location of accident: _____
Address and location of accident (loading dock, bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how the accident occurred (including events that occurred immediately before the accident):

Describe bodily injury(ies) sustained (be specific about body part(s) affected): _____

Recommendation(s) on how to prevent this accident from recurring: _____

Name of supervisor: _____ Last First Phone # _____

Name(s) of witness(es): _____ Phone # _____
Attach witness(es) report(s)

When did you report the accident to your supervisor? _____

To whom did you report the accident? _____

Did you require medical attention? ☐ Yes ☐ No ☐ Maybe

Name of your treating physician: _____ Phone # _____

Signature of employee: _____ Date: _____

Note: Form must be signed by hand in black or blue ink.

Accident Witness Statement

Policyholder: _____

Policy # _____

To be completed by the accident witness.

Injured employee's name: _____
Last First Middle

Name of witness: _____ Phone # _____
Last First Middle

Job title of witness: _____ Date of Hire: _____

Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Is witness any relation to the injured employee? ☐ Yes ☐ No If yes, what relation? _____

Location of accident: _____
Address and location of accident (loading dock, bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how the accident occurred (including events that occurred immediately before the accident):

Describe bodily injury(ies) sustained (be specific about body part(s) affected): _____

Recommendation on how to prevent this accident from recurring: _____

Name of witness' supervisor: _____ Phone # _____
Last First

Signature of witness: _____ Date: _____

Note: Form must be signed by hand in black or blue ink.

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.
Date of hire:	Job title or occupation:	Name of dept. normally assigned to:	How long has employee worked at job where accident 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(s) 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? If so, please specify:				

PLEASE INDICATE ALL OF THE FOLLOWING THAT 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: _____ Phone # _____ Date: _____

Supervisor's Signature: _____

Note: Form must be signed by hand in black or blue ink.