Chesapeake Employers Insurance™
Your workers' compensation specialist

Accident Investigation FORMS

How to use these important TOOLS

Includes:

- Employee's Report of Injury Form
- Accident Witness Statement Form
- Supervisor's Accident Investigation Form

Forms may be copied as needed.
Forms are also available for printing in pdf format online at www.ceiwc.com.

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

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 assure 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 completed 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 these forms completed, what do I do with them?

Please send the completed forms to your 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 the 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?

Of course, you cannot make an employee fill out the document. You can, however, stress the importance of getting his or her account of the accident to set the record straight and to help prevent the accident 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____
Last First Middle

Date of birth: ____/____/____ Home telephone # (______) ____________________

Marital status: M / D / W / S Height/Weight: ______" /______ lbs. ____Right- or ____left-hand dominant

Home address: ____

City: ______________________ State: ______ Zip Code: ____________

Current job position: ______________________ How long employed here: ____________

Social Security No.: _______-______-__________ Weekly salary: ____________________

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

Date of accident: ______________________ Time of accident: ____________

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

____

____

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

____

____

Recommendation on how to prevent this accident from recurring: ____________________

____

Name of supervisor: ______________________ Phone #____________
Last First

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 injury? ____________________

Do you require medical attention? Yes:_______ No:_______ Maybe:__________

Name of your treating physician: ______________________ Phone #____________

Signature of employee: ______________________ Date: ____________
Note: form must be signed by hand

Accident Witness Statement

Policyholder: ______________________

Policy #: ______________________

(To be completed by accident witness.)

Injured employee's name: ______________________
Last First Middle

Name of witness: ______________________ Phone # ______________
Last First Middle

Job title of witness: ______________________ How long employed here?________

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/name of building; area (bathroom, etc.)

Date of accident: ______________________ Time of accident: ______________

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

____

____

____

____

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

____

____

Recommendation on how to prevent this accident from recurring:______________________

____

Name of witness' supervisor: ______________________ Ph #______________
Last First

Signature of witness: ______________________ Date: ______________
Note: form must be signed by hand

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
____ Failure to secure
____ Horseplay
____ Improper dress
____ Improper guarding
____ Improper instruction
____ Improper maintenance
____ Improper protective equipment
____ Inoperative safety device
____ Lack of training or skill
____ Operating without authority
____ Physical or mental impairment
____ Poor housekeeping
____ Poor ventilation
____ Unsafe arrangement or process
____ Unsafe equipment
____ Unsafe position
____ 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
Note: form must be signed by hand

______________ Phone #

______________ Date

WORKERS' COMPENSATION COMMISSION

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PURSUANT TO COMAR 14.09.01.10 REQUIRING THE DISCLOSURE OF MEDICAL INFORMATION IN A WORKERS' COMPENSATION CLAIM

TO: ____

(Name of Record Holder)

PATIENT/CLAIMANT NAME:	SS#:	DATE OF BIRTH:	DATE OF ACCIDENT:

I, hereby, authorize you to give to:

____

(Name of Record Requestor)

a copy of all information developed by you in my medical record regarding the condition of the following part or parts of my body or my medical condition:

(Specify part or parts of body or medical condition.)

while under your observation or treatment or otherwise in your possession. This includes, but is not limited to, history, findings, office and patient charts and files, examination and progress notes, physical evidence prepared by you and any subsequent or future developments relating to my health or mental condition. ***This authorization is valid for up to one year from the date it is signed. I understand that I may revoke this authorization in writing at any time.***

Disclosure of medical information pursuant to this authorization is **NOT** prohibited under the **Health Insurance Portability and Accessibility Act** ("HIPAA").

The Health Insurance Portability and Accessibility Act (" HIPAA") at 45 CFR sect. 164.512 provides: " a covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault."

____

SIGNATURE of claimant/patient or authorized representative

____

DATE

10 East Baltimore Street • Baltimore, Maryland 21202-1641

410-864-5100 • Email: info@wcc.state.md.us • Web: http://www.wcc.state.md.us