IWIF Employee's Report of Injury

(To be completed by the employee)

Employee's name: _____ Male__ Female__
Last First Middle

Date of birth: ____/____/____ Home Telephone # (_____) _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Present classification: _____ How long employed here: _____

Social Security No.: _____-_____-_____ Bi-weekly salary: _____

Location of accident: _____
Name of building Area (bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: _____

_____

_____

_____

_____
(continue on other side, if necessary)

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

_____

_____

Recommendation on how to prevent this accident from recurring: _____

_____
(continue on other side, if necessary)

Name of Supervisor: _____
Last First Middle

Name(s) of Witness(es): _____
(Attach witness(es) report(s))

When did you report the accident to your supervisor? _____

Signature of employee: _____ Date: _____

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Accident Witness Statement

(To be completed by accident witness)

Injured Employee's name: _____
Last First Middle

Name of Witness: _____
Last First Middle

Job title of Witness: _____ How long employed here? _____

Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Location of accident: _____
Address/Name of building Area (bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: _____

_____

_____

_____

_____

_____
(continue on other side, if necessary)

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

_____

_____

Recommendation on how to prevent this accident from recurring: _____

_____
(continue on other side, if necessary)

Name of Supervisor: _____
Last First Middle

Signature of Witness: _____ Date: _____

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Supervisor's Accident Investigation

(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	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 was damaged?			Property owned by
What was employee doing when injury/illness occurred? What machine or tool? What operation?			
How did injury/illness occur? List all objects and substances involved.			
Part of body affected		Any prior physical defects? If so, what? Yes ☐ No ☐	
Nature and extent of injury/illness and property damaged (be specific)			

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

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

Supervisor's corrective action to insure this type of accident does not reoccur: _____

_____

_____

_____

Was employee retrained in the appropriate use of Personal Protective Equipment/Proper safety procedures? Yes ___ No ____

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? Yes ___ No ____

Supervisor's name	Supervisor's signature	Date

IWIF • 8722 Loch Raven Boulevard, Towson, MD 21286-2235 • www.iwif.com

Form may be copied as needed