ACCIDENT INVESTIGATION REPORT

Immediate completion of this form will help us to assist employees in obtaining workers' compensation benefits and help us prevent injuries to others.

Insured: Borough of Lavallette　　　　Today's Date:

Department:　　　　Time:

Part 1	**EMPLOYEE MUST COMPLETE AND ANSWER ALL QUESTIONS**			
First Name	M.I.	Last Name	Your Usual Occupation	Date of Birth
Home Address (Number and Street)		City	State	Zip
Home Phone # ( )	Sex ☐ Male ☐ Female	Marital Status	Length of Time Employed	
Date and Time of Accident ☐ AM ☐ PM		Exact Location Where Accident Occurred		
Occupation at Time of Accident			On Employer's Premises? ☐ Yes ☐ No	
Employee's Complete Description of Accident (Give details in explaining what happened.)				
Description of Injury (Give details including part of body injured.)				
Did anyone witness this accident? ☐ Yes ☐ No Witness Name(s):				
Employee's Signature			Social Security #	

SHOULD BE COMPLETED BY EMPLOYEE'S DIRECT SUPERVISOR

Part 2 **TO BE COMPLETED BY SUPERVISOR TO WHOM ACCIDENT REPORTED – REPORT ALL HAZARDS IMMEDIATELY!**

Supervisor's name and title:

1. Do you usually supervise this individual? ☐ Yes ☐ No For how long?
2. Was accident immediately reported? ☐ Yes ☐ No* (Explain below) (If no, when and how did you learn of the accident?)
3. Was employee working ☐ alone* (Explain below) ☐ with crew or fellow workers?
4. Was employee at work on company time? ☐ Yes ☐ No* (Explain below)
5. Did you physically inspect the area where injury occurred? ☐ Yes ☐ No* (Explain below)
6. Any unsafe conditions or unusual hazards present? ☐ Yes* ☐ No

7. Evidence of horseplay? ☐ Yes* ☐ No
8. Evidence of intoxication? ☐ Yes* ☐ No
9. Evidence of drug use? ☐ Yes* ☐ No
10. Was employer provided safety equipment in use? ☐ Yes ☐ No*
11. Was immediate medical attention necessary? ☐ Yes ☐ No If yes, where?
    If yes, where?
    By whom?
12. Is employee at work now? ☐ Yes ☐ No
    If no, when do you expect employee to return?
13. Are you satisfied that the accident/injury occurred as described above? ☐ Yes ☐ No*
14. Do you feel that accidents such as this can be avoided in the future? ☐ Yes* ☐ No
15. Describe action(s) taken to prevent recurrence: (safety talk with employees, eliminate unsafe practice, remove hazards, etc.)

16. Do you want to discuss this matter with the Claim Representative? ☐ Yes* ☐ No
17. Was employee wearing back support? ☐ Yes ☐ No*

Explain all * items by number

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Prepared by:___________________________________ Department: Date:
Signature

Please call 1-877-822-9368 to report this injury or fax completed form to 732-562-2815.