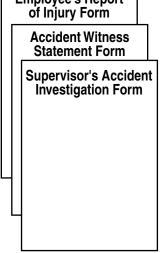
For State of Maryland Agencies **IWIF** Accident Investigation FORMS

How to use these important TOOLS

Includes: **Employee's Report**



Forms may be copied as needed. Forms are also available at https://www.ceiwc.com/iwifstate-of-maryland/index.html

Need Help?

If you would like assistance in setting up supervisory training on how to use these forms, please contact your IWIF 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.

IWIF Employee's Report of Injury

State Agency:

Policy #:

(To be completed by the employee only.) -

Employee's name:	Middle		Male	Female
Date of birth:/ Home telephone # (
Marital status: M / D / W / S Height/Weight:" /	lbs.	Right- or	_left-hand	l dominant
Home address:				
City:	State:	Zip Code:		
Current job position:	How lon	g employed her	re:	
Social Security No.: Weekly	salary:			
Location of accident:				
Address and location of accident (loa	ung uuck, bauno	JIII, ElC.)		
Describe bodily injury sustained (be specific about body part				
Recommendation on how to prevent this accident from recurring	ng:			
Name of supervisor:	P	hone #		
Name(s) of witness(es):(Attach witness(es) report(s))	P	hone #		
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:		
Injured Workers' Insurance Fund • 8722 Loch Raven Boulevard, Towson, MD 21286 Form may be copied as needed		w.ceiwc.com/iwif-sta	te-of-maryland	d <u>/index.html</u> 2/2016

IWIF Accident Witness Statement

State Agency:

Policy #:

Injured employee's name:	Loot	Firek	Middle
Name of witness:Last		First	Middle Phone#
Last Job title of witness:		Middle	How long employed here?
Home address of witness:			
City:			
Is witness any relation to the inj	ured employee?Ye	s <u>No</u> If yes	, what relation?
Location of accident:		r 4.4	
Date of accident:	Address/name of build	ding; area (bathroom, Ti	etc.) me of accident:
Describe fully how accident occ	urred (including events	that occurred ir	nmediately before the accident)
Describe bodily injury sustained	(be specific about body	part(s) affected):
Recommendation on how to prev	vent this accident from re	ecurring:	
Name of witness' supervisor:	Last	First	Phone#
Signature of witness:			_ Date:

- (To be completed by accident witness.) -

Supervisor's Accident Investigation Form

IWIF

State Agency:

Policy #:

(To be completed by the employee's supervisor or other responsible administrative official.)

Location where accident occurred:	Employer's Premises: Yes No Date of accident or illi		Date of accident or illness:	
	Job site: Yes No			
Who was injured?	Employee Non-employee		Time of accident: a.m.	
	If non-employee, specify		p.m.	
Length of time with firm: Job title or occupation:	Name of dept. normally assigned to:		s employee worked at job or illness occurred?	
What property/equipment was damaged?		Property/equ	ipment owned by:	
What was employee doing when injury/illness occurred? W	'hat machine or tool was being used? W	hat type of op	peration?	
How did injury/illness occur? List all objects and substand	ces involved.			
Was the accident the result of another party's negligence?	If so, name of the negligent par	ty:		
Part of body affected/injured?	Any prior physical conditions? If	so, what?		
	Yes No			
Nature and extent of injury/illness and property damaged (be	e specific):			
Do you have any concerns about this alleged accident or inju	ry? If so, please specify:			
PLEASE INDICATE ALL OF THE FOLLOW				

PLEASE INDICATE ALL OF THE FOLLOWING WHICH 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	Supervisor's signature	Phone #	Date	
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