Claims | Claims Management of Missouri, LLC
Mgmt of MO

Employee Incident / Injury Report

- Workers' Compensation –

This form is to be filled out by the Employee/Injured Worker any time an accident is reported. This form should be sent to CLAIMS MGMT, along with the Supervisor's Accident Report pertaining to the same accident. Use additional sheets if necessary.

Name of Employee: _____
Date of Accident/Incident: _____
Time of Accident/Incident: _____ AM (or) PM
Work Schedule / Shift / Hours: _____

Describe in detail how the incident occurred, including the task or activity at the time of the incident and any object or substance that contributed:

What actually caused the incident/accident? In order of importance, number up to three (3) choices with #1 being the most significant.

_____ Defective equipment
_____ Unsafe facility/environment
_____ Improper housekeeping/storage
_____ Protective equipment not provided
_____ Protective equipment not used (including seat belts)
_____ Inattention or distraction
_____ Actions of another: Who? _____ Details: _____
_____ Other: _____
_____ Inadequate maintenance
_____ Unsafe planning/method
_____ Insufficient training/authorization
_____ Infraction of rules/procedures
_____ Instructions not followed

In your opinion – what actions should be taken to prevent a similar re-occurrence?

_____

Safety / Drug - Alcohol Violation:
Were you written up?

List any Witnesses:

Additional Comments:

Employee Signature: _____ Date: _____
Supervisor Signature: _____ Date: _____