ICW GROUP
Insurance Companies

S.T.E.P. UP TO A SAFER WORKPLACE
Accident Investigation Form

After reporting your injury claim to ICW Group (as applicable), complete this form for your accident investigation records.

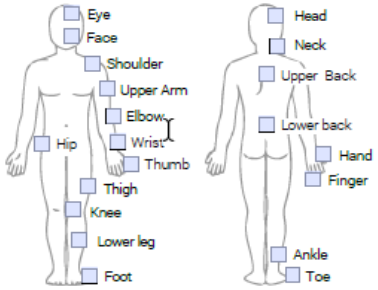
Report completed by _____ **ID #** _____
Title _____ **Date** _____
Department _____

Report type ○ Death ○ Lost time ○ Dr visit ○ First aid ○ Near miss
○ Employee ○ Supervisor ○ Safety committee ○ Safety manager ○ Other

Step 1: Injured employee (complete this part for each injured employee)

Employee name _____
Date of birth _____
Gender ○ Female ○ Male ○ Non-disclosed
Job title _____
Department _____
Original hire date _____
Time in current job _____
Shift hours Start _____ End _____
Job category ○ Full time ○ Part time ○ Seasonal ○ Temporary

Area of body injured



Injury description

Step 2: Incident description

Location occurred _____
Incident Date/Time _____ **Time reported** _____
Part of workday ○ Regular time ○ Overtime ○ Other (describe)
○ Entering work ○ Leaving work
○ On lunch/meal ○ On break

PPE worn at time of incident

☐ Safety glasses ☐ Hard hat ☐ Steel toe shoes ☐ Other (describe)
☐ Safety goggles ☐ Bump cap ☐ Slip resistance
☐ Face shield ☐ Respirator ☐ Fall protection
☐ Sound protection ☐ Welding hood ☐ Gloves

Equipment involved