DynamicHR
Total Human Resource Administration

ACCIDENT INVESTIGATION REPORT (Please Print Clearly)

Internal Use Only Date Received: ________________
Claim sent to ( ) WC Insurance Carrier date: ______________________________ ( ) Mailed ( ) Telephoned

Claim Number: _____________________ W/C Contact: _______________________ Initials: ______________

IMPORTANT! If a workplace injury or illness is reported to you, immediately refer the injured employee to the pre-designated medical clinic. All incidents, regardless of severity, must be reported to DynamicHR within 24 hours. Please complete this form and fax it to DynamicHR at 248-370-0968.

THERE ARE STRICT TIME PERIODS IN WHICH ALL CLAIMS MUST BE REPORTED. LATE REPORTING MAY RESULT IN FINANCIAL PENALTIES IMPOSED BY THE STATE.

Employee Information:

Employee: _______________________________________ Social Security Number: __________________________________

Address:____ City:______________________ State:________ Zip:_________

Home Phone:________________________ Cell Phone:________________________ Email:____________________________

Marital Status: Married ( ) Single/Divorced ( ) Number of Dependents:______________

Does the injured employee speak English? Yes ( ) No ( )

Date of Birth: ______/______/______ Date of Hire: ______/______/______

Job Title: ___________________________ Hours Worked in Average Day:________ Days Worked in Average Week:________

Worksite Employer Information:

Temporary Service Agency: ________________________________Address ____

Worksite Employer Name: __________________________________ Worksite Employer Contact: _________________________

Worksite Employer Contact Phone:_____________________ Cell:______________________

Accident Information:

Date of incident/accident/injury/illness: ______/______/______ Date reported to Dynamic: ______/______/______

Time Employee Began Work on Date of Incident: ________________AM PM Time of Incident: _________________AM PM

Address where the accident/injury/illness occurred:____

County where the accident/injury/illness occurred: ______________________________

Describe the injury or illness (i.e. cut on hand, fractured finger, object in eye): ____

Part of body directly injured (i.e. back, **left** wrist, **right** eye): ____

Has the employee died? ( ) Yes ( ) No If yes, date of death: _______________________________________

Did the employee receive medical treatment? No ( ) Yes ( )

If yes, where? ____ Contact Name: _____________________________

Address: ____ Phone: ____________________________________

Did the employee miss any work? Yes ( ) No ( ) Last day employee worked: ____________________

Has the employee returned to work? Yes ( ) No ( ) Date employee returned to work: ________________

Was the employee performing their normal job duties when the incident occurred? No ( ) Yes ( )

What was the employee doing before the incident? ____

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Incident Description ____

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How did the incident occur? (Please describe fully the events that resulted in the incident / exposure. Describe what happened, how it happened and anything about the scene that may have contributed to the incident occurring. Attached additional sheet if necessary)

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Name of witnesses to incident / exposure (First and Last name and telephone numbers):

Name:____________________________________ Phone:_____________________________

Name:____________________________________ Phone:_____________________________

Name:____________________________________ Phone:_____________________________

Do you question the validity of the claim of injury/illness? No ( ) Yes ( ) If yes, why?: __________________________________

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Additional Comments:

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Completed by: ______________________________________ Phone: _____________________________ Date: ________________