# WORKER'S COMPENSATION - ACCIDENT INVESTIGATION REPORT

**I. Identification of the Accident:**

Name of Injured: _____ Date of Accident: _____

Time of Accident: _____ Location of Accident: _____

**II. Nature of Injury:**

Exact part of body affected and type of injury:

_____

_____

**Description of HOW and WHY accident occurred:**

_____

_____

_____

Names of witnesses:

_____

**III. Accident Prevention Information:**

Equipment, tool, or thing causing injury: _____

Was accident caused by failure to use or observe safety practices, policies, or regulations?

_____

**IV. Corrective Action:**

What corrective action can be done to prevent a recurrence of this accident/injury?

_____

_____

Comments/Recommendations (by Safety Committee, Safety Director, or Supervisor):

_____

_____

Person(s) responsible for corrective action:

_____

Safety Director/Manager Review:

_____

_____ _____

Signed Date

Please complete and mail or fax to:

**Catholic Mutual Group**
**ATTN: Diocesan Claims/Risk Manager**
**P.O. Box 44983**
**Madison, WI 53744-4983**

**Phone (866) 833-3090 Fax (608) 833-3794**