Catholic Mutual. . ."CARES"

EMPLOYEE INJURIES

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 item 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: Ben Burrow, Assistant Claims/Risk Manager
3710 East Avenue South
La Crosse, WI 54601
Work: 608-519-9890
Cell: 608-386-6406
BBurrow@catholicmutual.org

(Revised 9/2018)