

# OPPORTUNITIES, INC ACCIDENT INVESTIGATION REPORT

**SUPERVISOR**

**Employee**

**Consumer**

**To be completed by supervisor, case manager, and/or employee**

**ATTENTION:** It is critical that all accidents be reported to the HR Department immediately, even if only partial information is available at that time.

EMPLOYEE NAME		BIRTH DATE	
ADDRESS		CITY	STATE ZIP
HOME PHONE NUMBER (INCLUDE AREA CODE) (                    )	CARE GIVERS NAME	CAREGIVERS PHONE NUMBER (                    )	

LENGTH OF TIME ON CURRENT JOB	START DATE	WAGE	SHIFT <input type="checkbox"/> 1ST <input type="checkbox"/> 2ND <input type="checkbox"/> 3RD	HOURS TO	AM PM	DAYS OF WEEK
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DATE OF ACCIDENT (MO, DAY, YR.)	WHICH PLANT/AREA	TIME AM PM	DATE REPORTED
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DID THE INJURED PARTY LEAVE WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO   TIME	AM PM	RETURN TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO   TIME	AM PM	WAS MEDICAL ATTENTION SOUGHT? <input type="checkbox"/> YES (IF YES PLEASE FILL OUT NEXT LINE) <input type="checkbox"/> NO
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NAME OF DOCTOR	NAME OF HOSPITAL/CLINIC	ER <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE TO DOCTOR
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WHO ASSISTED WITH THE INJURY?	TYPE OF ASSISTANCE
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COMPANY AT WHICH THE ACCIDENT OCCURRED?	NAME OF TOOLS OR MACHINES BEING USED
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DESCRIBE ACTIVITIES OF EMPLOYEE WHEN INJURY OR ILLNESS OCCURRED AND WHAT TOOLS, MACHINERY, OBJECTS CHEMICALS, ETC. WERE INVOLVED.

DESCRIBE THE INJURY (INCLUDING BODY PARTS, RIGHT/LEFT, ETC.)
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NAME OF WITNESS(ES)

WHAT ACTIONS CAN BE TAKEN TO PREVENT REOCCURRENCES?

HAVE THEY EVER HAD A SIMILAR PROBLEM    YES    NO   IF YES, EXPLAIN:

SIGNATURE OF PERSON COMPLETING REPORT	DATE
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**Supervisor/Case Manager, Please complete below**

Injury **IS** work related    Injury **IS NOT** work related

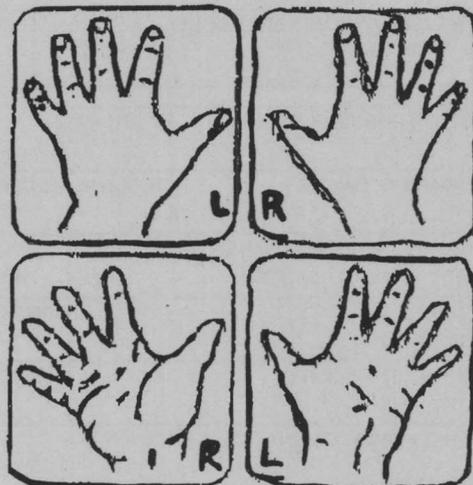
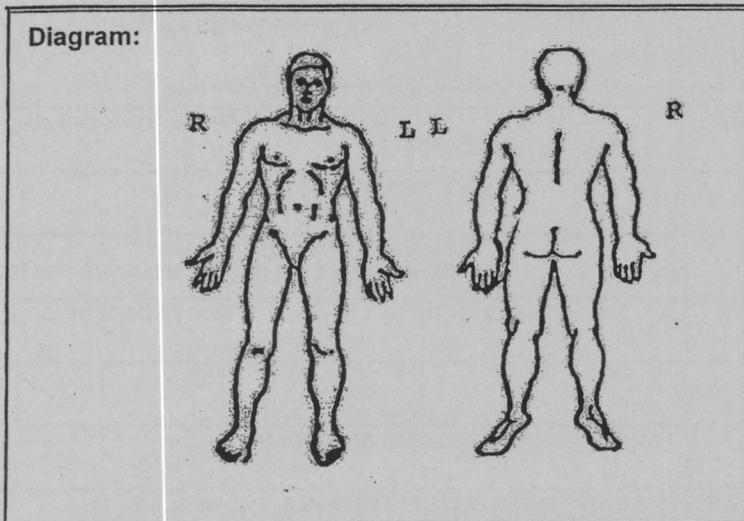
HAS CARE PROVIDER BEEN CONTACTED?    YES    NO   IF NO, EXPLAIN: \_\_\_\_\_

IS CLAIM SUSPICIOUS?    YES    NO   IF YES, EXPLAIN: \_\_\_\_\_

PLEASE FOLLOW UP THE FOLLOWING DAY TO HELP DETERMINE IF INJURY SHOULD BE CONSIDERED AN ACCIDENT VERSUS AN INCIDENT. PLEASE CONTACT THE HR DEPARTMENT.

**(OVER)**

Using an "x", please indicate on the diagram where you are experiencing discomfort.



**COMMENTS** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE READ CAREFULLY**

I hereby certify that all statements and answers provided by me in this report are complete and true to the best of my knowledge. I understand that any misrepresentation or deliberate omission of a material fact may be justification for termination of employment and/or other disciplinary action. Any person who knowingly and with intent to defraud or deceive any employer, insurance company, or filed a statement of claim containing any false or misleading information is guilty of a felony of the third degree. Section 11. of Wisconsin Compensation Statute 102.13(2) and (3): An employee who reports an injury alleged to be work-related or files an application for hearing waives any physician/patient privilege.