FLORIDA RESOURCE MANAGEMENT

Workers' Compensation Accident / Incident Report

Claims Reporting Hot Line: 1-941-343-6160

Incident Location Information

Employer Name: _____ Location Number: _____

Address: _____ Insurance Carrier: _____

City: _____ Policy Number: _____

State: _____ Zip: _____ County: _____ Country: USA

Contact Person: _____ Phone: _____

Email Address: _____ Fax: _____

ATTENTION:

This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains. In addition, this form is required for each injury/illness recorded on your OSHA 300 log, regardless of whether or not the injury/illness is compensable per Workers' Compensation.

SECTION I: GENERAL INFORMATION

REPORTED BY: _____ DATE REPORTED TO MGR: _____

INVESTIGATED BY: _____ DATE OF INVESTIGATION: _____

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____ ☐ AM ☐ PM

TYPE OF INCIDENT: ☐ Near Miss / 'Close Call' ☐ Accident involving an injured or ill employee

LOCATION OF INCIDENT: _____

INJURED EMPLOYEE: _____ ☐ N/A - No employees were injured

WITNESS(ES): _____

WHAT WAS THE EMPLOYEE DOING IMMEDIATELY BEFORE THE INCIDENT OCCURRED?

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DESCRIBE WHAT HAPPENED:

DESCRIBE WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE:
(i.e. concrete floor; chlorine; radial arm saw. If this question does not apply to the incident, leave it blank)

DESCRIBE ANY RELATED SAFETY TRAINING PROVIDED PRIOR TO THE INCIDENT:

WAS PPE REQUIRED? ☐ Yes ☐ No WAS PPE WORN? ☐ Yes ☐ No ☐ N/A

TYPE: _____

SECTION II: ROOT CAUSE AND PREVENTATIVE ACTION

WHAT IS THE ROOT CAUSE OF THE INCIDENT OR ACCIDENT?

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DESCRIBE ANY CORRECTIVE ACTION TAKEN TO PREVENT RE-OCCURANCE:

SECTION III: INJURED OR ILL EMPLOYEE INFORMATION

DATE OF INJURY/ILLNESS: _____ TIME OF INJURY / ILLNESS: _____ ☐ AM ☐ PM

NAME: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF HIRE: _____ DATE OF BIRTH: _____ TIME EMPLOYEE BEGAN WORK / SHIFT ON THE DATE OF INJURY: _____ ☐ AM ☐ PM

SECTION IV: INJURY/ILLNESS INFORMATION

BODY PART AFFECTED:
(Ex: Left Index Finger) _____

TYPE OF INJURY / ILLNESS:
(Ex: Sprain, Laceration, Fracture) _____

FIRST AID PROVIDED:
(Ex: Flushed eyes with water) _____

WAS MEDICAL TREATMENT BY A PHYSICIAN REQUIRED FOR TREATEMENT: ☐ Yes ☐ No

If yes, complete sections V through VI and report the injury by calling Florida Resources Management at 1-941-343-6160. Completion of this investigation report is not a substitute for reporting the claim.

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SECTION V: MEDICAL TREATMENT RENDERED

DATE THE EMPLOYEE RECEIVED MEDICAL TREATMENT: _____ ☐ Refused by employee

Signature of employee if refused: _____

NAME OF MEDICAL FACILITY: _____

NAME OF PHYSICIAN OR HEALTH CARE PROFESSIONAL: _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIPCODE: _____

TYPE: ☐ Hospital Emergency Room ☐ Walk-In Medical Clinic ☐ Authorized Physician's Office

WAS THE EMPLOYEE HOSPITALIZED OVERNIGHT AS AN "INPATIENT": ☐ Yes ☐ No ☐ N/A

WAS THE INJURY FATAL? ☐ Yes ☐ No IF YES, ENTER DATE OF DEATH: _____

SECTION VI: REPORTING & RECORD- KEEPING REQUIREMENTS

DATE INJURY OR ILLNESS WAS REPORTED TO INSURNCE CARRIER: _____

INSURANCE CARRIER CLAIM NUMBER _____

WAS THE INJURY REPORTED TO INSURNCE CARRIER WITHIN 24HRS HOURS? ☐ Yes ☐ No
If No, please explain why not:

WAS A POST-ACCIDENT DRUG TEST PERFORMED? ☐ Yes ☐ No If No, please explain why not:

WAS THE INJURY ENTERED ON THE OSHA 300 LOG? ☐ Yes ☐ No ☐ N/A CASE LOG#: _____

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SECTION VII: SIGNATURES

INJURED EMPLOYEE: _____ DATE: _____

INVESTIGATOR: _____ DATE: _____

MANAGEMENT REVIEW AND FOLLOW-UP ACTION

REVIEWED BY: _____ REVIEWED ON: _____

FOLLOW-UP ACTION PLAN:

_____

FOLLOW-UP COMPLETED ON: _____ SIGNATURE: _____

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WITNESS STATEMENT 1

PUT IN YOUR OWN WORDS WHAT YOU SAW HAPPEN.

WITNESS SIGNATURE_____ DATE_____

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WITNESS STATEMENT 2

PUT IN YOUR OWN WORDS WHAT YOU SAW HAPPEN.

WITNESS SIGNATURE_____ DATE_____