

## Accident Report Guide

This Accident Report Package must be completed fully for **every work-related accident or illness** and for **every injured person**.

### This report will:

1. Assist employees in obtaining immediate medical treatment
2. Inform the supervisor/authority how the accident happen
3. Record the accident, the follow-up for future prevention

### IMPORTANT OSHA LEGAL REQUIREMENTS and Common Asked Questions:

**1904.39(a) Basic requirement.** Within eight (8) hours after the death of any employee from a work-related incident or the in-patient hospitalization of three or more employees as a result of a work-related incident, you must orally report the fatality/multiple hospitalization by telephone or in person to the Area Office of the Occupational Safety and Health Administration (OSHA), U.S. Department of Labor, that is nearest to the site of the incident. You may also use the OSHA toll-free central telephone number, **1-800-321-OSHA** (1-800-321-6742). –YOU MUST CALL OSHA in case of an amputation within eight hours-.

#### **1904.39(b) Implementation.**

**1904.39(b)(1) If the Area Office is closed, may I report the incident by leaving a message on OSHA's answering machine, faxing the area office, or sending an e-mail?** No, if you can't talk to a person at the Area Office, you must report the fatality or multiple hospitalization incidents using the 800 number.

**1904.39(b)(2) What information do I need to give to OSHA about the incident?** You must give OSHA the following information for each fatality or multiple hospitalization incidents:

**1904.39(b)(2)(i)** The establishment name;

**1904.39(b)(2)(ii)** The location of the incident;

**1904.39(b)(2)(iii)** The time of the incident;

**1904.39(b)(2)(iv)** The number of fatalities or hospitalized employees;

**1904.39(b)(2)(v)** The names of any injured employees;

**1904.39(b)(2)(vi)** Your contact person and his or her phone number; and

**1904.39(b)(2)(vii)** A brief description of the incident.

**1904.39(b)(3) Do I have to report every fatality or multiple hospitalization incident resulting from a motor vehicle accident?** No, you do not have to report all of these incidents. If the motor vehicle accident occurs on a public street or highway, and does not occur in a construction work zone, you do not have to report the incident to OSHA. However, these injuries must be recorded on your OSHA injury and illness records, if you are required to keep such records.

**1904.39(b)(4) Do I have to report a fatality or multiple hospitalization incident that occurs on a commercial or public transportation system?** No, you do not have to call OSHA to report a fatality or multiple hospitalization incidents if it involves a commercial airplane, train, subway or bus accident. However, these injuries must be recorded on your OSHA injury and illness records, if you are required to keep such records.

**1904.39(b)(5) Do I have to report a fatality caused by a heart attack at work?** Yes, your local OSHA Area Office director will decide whether to investigate the incident, depending on the circumstances of the heart attack.

**1904.39(b)(6) Do I have to report a fatality or hospitalization that occurs long after the incident?** No, you must only report each fatality or multiple hospitalization incident that occurs within thirty (30) days of an incident.

**1904.39(b)(7) What if I don't learn about an incident right away?** If you do not learn of a reportable incident at the time it occurs and the incident would otherwise be reportable under paragraphs (a) and (b) of this section, you must make the report within eight (8) hours of the time the incident is reported to you or to any of your agent(s) or employee(s).

## General Supervisor's Responsibility

### Main Objective

**Prevention of Injuries:** Safety is a key to reducing injuries, thereby, controlling workers' compensation cost

### After Injury:

When a supervisor receives notice or has knowledge of a work related injury or illness, he/she must:

1. Determine the worker's immediate medical needs and arrange treatment (IN CASES OF A SERIOUS ACCIDENT OR INJURY DIAL 911)
2. Refer the employee to the nearest Medical Provider Network clinic
3. Notify to Manager, Safety Officer, Human Resources Manager or Workers Compensation Office

### First Day Supervisor's Responsibility:

1. Identify the cause of the injury or illness and take the necessary steps to secure the workplace to avoid further injury.
2. If equipment was involved in the injury (broken chair, ladder, machinery, vehicle, etc.), take necessary steps to secure the evidence.
3. Perform an accident investigation (if possible, recreate the accident and take pictures).
4. Complete the "Supervisor Accident Report" within 24 hours of injury and forward the completed form to the office.
5. Attach all pictures of the accident to this report.
6. **Within one working day** of notice or knowledge of incident, complete line 1 and the employer section with the exception of line 13 of the Employee Claim Form (DWC-1)
  - a. **Remove the gold copy (worker's Compensation Office Acknowledgment) of the employee Claim Form (DWC-1).**
  - b. Provide the worker the DWC-1 Claim Form (or his/her dependents or agent) within one working day. The form may be delivered personally or by first-class mail.
    - i. NOTE: completion of the remainder of the claim form is the responsibility of and at the discretion of the employee.
  - c. Upon return of the claim form, make sure the employee has removed the pink copy ("Employee's Temporary Receipt") of Employee Claim Form (DWC-1)
  - d. Forward the remaining white (original) copy to the office.
7. Provide the worker the "Employee Accident Report". Ask him/her to fill it out completely, including the section III "Employee Authorization".
8. Complete the "Employer's First Report of Injury/Illness" (form "5020")

Below are forms (**please print neatly in ink**).

**ATTENTION:** This form contains information relating to employee's work-related injury and must be used in a manner that protects the confidentiality of the employee to the maximum extent possible.

**Section I: EMPLOYEE INFORMATION**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Sex: M  F  Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Job Title: \_\_\_\_\_ Department: \_\_\_\_\_

Supervisor's Name (printed): \_\_\_\_\_

**Section II: INJURY/ILLNESS INFORMATION**

Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_ a.m. p.m. Time Shift Began: \_\_\_\_\_ a.m. p.m.

Date Reported: \_\_\_\_\_ Time: \_\_\_\_\_

Is this injury related to a traffic accident? Yes  No

Were any other employee injured at the same time? Yes  No

Where did illness/injury occur? (address and city): \_\_\_\_\_

What were you doing before the accident occurred? \_\_\_\_\_

Was this part of your normal job duty? Yes  No

What happened? \_\_\_\_\_

Employee Initials \_\_\_\_\_

## Employee Accident Report (page 2 of 3)

**BODY PART:** Check the appropriate box(s) and on the line provided specify the location by indicating LE for Left, RT for Right, BO for Both, FR for Front, and BA for Back.)

<input type="checkbox"/> Head/Skull _____	<input type="checkbox"/> Arm _____	<input type="checkbox"/> Leg _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Back, Upper
<input type="checkbox"/> Nose _____	<input type="checkbox"/> Elbow _____	<input type="checkbox"/> Hip _____	<input type="checkbox"/> Chest _____	<input type="checkbox"/> Back, Mid
<input type="checkbox"/> Ear _____	<input type="checkbox"/> Ankle _____	<input type="checkbox"/> Foot _____	<input type="checkbox"/> Lung _____	<input type="checkbox"/> Back, Lower
<input type="checkbox"/> Tooth _____	<input type="checkbox"/> Finger _____	<input type="checkbox"/> Knee _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Neck _____
<input type="checkbox"/> Mouth _____	<input type="checkbox"/> Wrist _____	<input type="checkbox"/> Toe _____	<input type="checkbox"/> Psyche _____	<input type="checkbox"/> Eye _____
<input type="checkbox"/> Shoulder _____	<input type="checkbox"/> Hand _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

**NATURE OF INJURY:** (Check appropriate box.)

<input type="checkbox"/> Irritation/inflammation	<input type="checkbox"/> Emotional Stress	<input type="checkbox"/> Trauma/Contusion
<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Heart	<input type="checkbox"/> Puncture/Laceration
<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Bite	<input type="checkbox"/> Abrasion
<input type="checkbox"/> Fracture	<input type="checkbox"/> Exposure (To what)	
<input type="checkbox"/> Other		

Describe in your own words the type of injury or illness: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What object or substance directly harmed you? \_\_\_\_\_  
 \_\_\_\_\_

**Help us: What could be done to prevent this kind of accident in the future? (Actions, guards, rules, etc.)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Report prepared by** (if different from the injured employee):

\_\_\_\_\_

Employee Initials \_\_\_\_\_

**Section III: EMPLOYEE AUTHORIZATION**

**Check ALL the statements that you understand and agree**

**I understand** that it is my right to apply for Workers' Compensation benefits.

**I authorize release of medical information regarding this accident to this company and their claim administrators.**

**I declare** that all my declarations on this Employee Accident Report form are true.

**I understand** it is a criminal offense to file a false claim to obtain workers compensation benefits.

**I understand** that I can receive medical attention only through the company's Medical Provider Network.

*Declaration of inability to read and/or write (must be fill only if the employee doesn't how to read):*

**I declare** that this form was read to me in a language that I can understand, and I agree with all the statements above, declarations and accident description on this employee accident report Yes  No

**Signing this form you understand:** Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

EMPLOYEE SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**Signing this form you understand:** Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

Witness Signature: \_\_\_\_\_

DATE: \_\_\_\_\_

## Witness of Accident Report

### Section IV: Witness Declaration

Date: \_\_\_\_\_

Witnesses Name: \_\_\_\_\_

Job Title: \_\_\_\_\_ Department: \_\_\_\_\_

Name of the person injured \_\_\_\_\_

Where were you when the accident happened? \_\_\_\_\_

\_\_\_\_\_

Did any object or substance directly harmed the injured? (If yes, explain) \_\_\_\_\_

\_\_\_\_\_

How many employees were injured? \_\_\_\_\_

What did you see (how did the accident happen)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**In your opinion, what could be done to prevent this kind of accident in the future? (Actions, guards, rules, etc.)**

\_\_\_\_\_

\_\_\_\_\_

**Report prepared by** (if different from the injured employee): \_\_\_\_\_

I understand it is a criminal offense to file a false claim to obtain workers compensation benefits.

***Declaration of inability to read and/or write:***

I declare that this form was read to me and I agree with all the statements above, declarations and accident description on this witness accident report Yes  No

**Signing this form you understand:** Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

EMPLOYEE SIGNATURE: \_\_\_\_\_

Section V: SUPERVISOR REPORT

Supervisors' Name: \_\_\_\_\_

Name of the person injured \_\_\_\_\_

This illness/injury was reported to me on: Date: \_\_\_\_\_ Time: \_\_\_\_\_ am. pm.

How was the illness/injury reported?  In person  Phone  Other

If other, explain: \_\_\_\_\_

<b>Type of Injury / Illness (Check One)</b>	<input type="checkbox"/> Medical Treatment Expected
	<input type="checkbox"/> Incident Report / First Aid Only

Was employee performing usual job duties when injured? Yes  No

Where did illness/injury occur? (address and city):  
\_\_\_\_\_  
\_\_\_\_\_

Did employee work after date of injury?

If yes, date returned: \_\_\_\_\_ If no, anticipated date of return: \_\_\_\_\_

Is there any reason to believe this may NOT be a valid claim? Yes  No

If incident was witnessed, provide the name(s), address, and phone number of the witness(s):

Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

It is any pictures of the accident? Yes  No

If YES, where are they? \_\_\_\_\_

Did you perform an accident investigation? Yes  No

If NO, Why? \_\_\_\_\_

Did you perform an accident recreation? Yes  No

If NO, Why? \_\_\_\_\_



**CAUSE OF INJURY/ILLNESS:** (Check appropriate box.)

<input type="checkbox"/> Design of workstation/building	<input type="checkbox"/> Uneven or slippery surface
<input type="checkbox"/> Rules/procedures not followed	<input type="checkbox"/> Horseplay
<input type="checkbox"/> Incorrect body position in relation to work	<input type="checkbox"/> Exposure (chemical, noise, etc.)
<input type="checkbox"/> Incorrect tools or mechanical aids used	<input type="checkbox"/> Vehicle operation
<input type="checkbox"/> Equipment operated incorrectly	<input type="checkbox"/> Congested area (storage)
<input type="checkbox"/> Environmental factors (weather, lighting)	<input type="checkbox"/> Animal or insect
<input type="checkbox"/> Action of fellow employee/member of public	<input type="checkbox"/> Conflict with supervisor
<input type="checkbox"/> Protective devices or guards	<input type="checkbox"/> Inattention or distraction
<input type="checkbox"/> Rules/procedures inadequate	
<input type="checkbox"/> Other (please explain)	

**SOURCE OF INJURY** (Check appropriate box.)

<input type="checkbox"/> Structure	<input type="checkbox"/> Equipment/Tools	<input type="checkbox"/> Material
<input type="checkbox"/> Objects	<input type="checkbox"/> Environment	<input type="checkbox"/> Person
<input type="checkbox"/> Other		

**PREVENTATIVE MEASURES** (Check one or more actions.)

<input type="checkbox"/> Provide more complete job instruction	<input type="checkbox"/> Update or revise procedures
<input type="checkbox"/> Enforce work rule	<input type="checkbox"/> Provide safe equipment
<input type="checkbox"/> Provide proper tools, equipment	<input type="checkbox"/> Reinforce employee training
<input type="checkbox"/> Provide personal protective equipment	<input type="checkbox"/> Modify workstation or building
<input type="checkbox"/> Contract third party to effect correction	
<input type="checkbox"/> Other (please explain below)	

How can this accident can be prevented on the future? \_\_\_\_\_

Is further investigation required? Yes  No

Did the employee seek MEDICAL TREATMENT? Yes  No

Is this a re-aggravation of previous injury? Yes  No  Date of initial injury: \_\_\_\_\_

**Signing this form you understand:** Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

Supervisor Signature: \_\_\_\_\_

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		Please complete in triplicate (type if possible) Mail to copies to:		OSHA CASE NO.			
				FATALITY <input type="checkbox"/>			
Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.		California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or teletype to the nearest office of the California Division of Occupational Safety and Health.					
EMPLOYER	1. FIRM NAME			1a. Policy Number			
	2. MAILING ADDRESS: (Number, Street, City, Zip)			2a. Phone Number			
	3. LOCATION if different from Mailing Address (Number, Street, City and Zip)			33. Location Code			
	4. NATURE OF BUSINESS; e.g. Painting contractor, wholesale grocer, sawmill, hotel, etc.			6. State an employment in surance acct. no			
INJURY OR ILLNESS	6. TYPE OF EMPLOYEE <input type="checkbox"/> Private <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> School District <input type="checkbox"/> Other Govt.					INDUSTRY	
	7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy) <small>Click here to enter a date.</small>		8. TIME INJURY/LLNESS OCCURRED _____AM _____PM		9. TIME EMPLOYEE BEGAN WORK _____AM _____PM		
	10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)		11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER OF INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	12. DATE LAST WORKED (mm/dd/yy)		13. DATE RETURNED TO WORK (mm/dd/yy)		14. IF STILL OFF WORK, CHECK THIS BOX: <input type="checkbox"/>		
	15. PAID FULL DAYS WAGES FOR DATE OF NJURY OR LAST DAY WORKEO? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. SALARY BEING CONTINUED? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. DATE OF EMPLOYER'S KNOWLEDGE NOTICE OF INJURY/ILLNESS (mm/dd/yy)		
	18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)					SEX	
	19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g. Second degree burns on right arm, tendonitis on left elbow, lead poisoning					AGE	
	20. LOCATION WHERE EVIENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)			20a. COUNTY		21. ON EMPLOYER'S PREMISES? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	22. DEPARTMENT WHERE EVIENT OR EXPOSURE OCCURRED, e.g. Shipping department, machine shop.			23. Other Workers injured or ill in this event? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g. Acetylene, welding torch, farm tractor, scaffold					DAILY HOURS	
	26. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g. Welding seams of metal forms, loading boxes onto truck					DAYS PER WEEK	
	26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g. Worker slipped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY					WEEKLY HOURS	
	27. Name and address of physician (number, street, city, zip)					WEEKLY WAGE	
	27a. Phone Number					COUNTY	
28. Ho spitalized as an inpatient overnight? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes then, name and address of hospital (number, street, city, zip)					NATURE OF INJURY		
28a. Phone Number					PART OF BODY		
29. Employee treated in emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No					SOURCE		
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 this information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2. Note: Shaded boxes indicate confidential employee information as listed in CCR Title 814300.35(b)(2)(E)2.							
EMPLOYEE	30. EMPLOYEE NAME		31. SOCIAL SECURITY NUMBER		32. DATE OF BIRTH (mm/dd/yy)		
	33. HOME ADDRESS (Number, Street, City, Zip)				33a. PHONE NUMBER		
	34. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)		36. DATE OF IIRE (mm/dd/yy)		
	37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week _____ total weekly hours			37a. EMPLOYMENT STATUS <input type="checkbox"/> Regular, full-time <input type="checkbox"/> part-time <input type="checkbox"/> temporary <input type="checkbox"/> seasonal		37b. UNOER WHAT CLASS CODE OF OUR POLICY WHERE WAGES ASSIGNED	
	38. GROSS WAGES/SALARY per			39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Completed By (type or print)			Signature & Title				
Date (mm/dd/yy)							
* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.36), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.							