**Employer Name & Logo Here**

Workers Comp Checklist

#  Immediately after Injury Occurs

* If it is an emergency, allow Employee to seek emergency care Immediately
* The Employee fills out the Notice of Accident (NOA) Form (Page 2).

**NOTE: The NOA in this document is for Employers who allow the Employee to make the initial selection for medical treatment**

* The Employees Supervisor or other Responsible Representative Signs the NOA Form (Page 2)
* If Medical attention is required, continue. If not, skip to the “Reporting Section”
* Send employee to their Health Care Provider of choice with the “Return-to- Work Cover Letter” (Page 3) and the “Providers Report of Physical Ability Form” (Pages 4-5)
* The Employee turns in their Providers report of Physical Ability Form (Pages 4- 5) after it has been completed by their Health Care Provider
* If the employee needs a prescription, give them the “Optum First Fill Card” (Page 6)

#  Reporting to Workers Compensation

* The Employees Supervisor or other Responsible Representative will work with the Business Office and/or the HR Department to fill out the “First Report of Injury” Form (Page 7). The Employee and the Supervisor or other Responsible Representative both need to sign this form.
* The Employees Pillar Director will complete the “Incident Investigation Report” (Pages 8-9) and will sign once completed.
* The Employees Supervisor or other Responsible Representative will email the completed NOA Form (Page 2), the “First Injury Report” Form (Page 7), and the “Incident Investigation Report” (Pages 8-9) to the Business Office and/or the HR Department to enter directly into the claims software (ICE) to be submitted to the Claims Administrator (CCMSI) or email to [nmpsiawc@ccmsi.com](mailto:nmpsiawc@ccmsi.com)

**NOTE: These forms must be sent to the Claims Administrator within 72 hours of the incident**

* If the employee received medical care, send the completed “Physical Ability Form” to the adjuster assigned to the new file



**NOTICE OF ACCIDENT OR OCCUPATIONAL DISEASE DISABLEMENT NOTIFICACIÓN DE ACCIDENTE O ENFERMEDAD DE OFICIO**

In accordance with New Mexico law, Section 52-1-29, Section 52-3-19 and Section 52-1-49, NMSA 1978; NMAC 11.4.4.11

*Conforme a la Ley de la Compensación de los Trabajadores, Sección 52-1-29 ,Sección 52-3-19 y Sección 52-1-49, NMSA 1978; NMAC 11.4.4.11*

I, ,was involved in an on-the-job accident or was disabled by an occupational disease

*Yo,* (name of employee*/nombre del empleado) me lastimé en un accidente en el trabajo o fui incapacitado por enfermedad de oficio*

at approximately ,on , 20 . Date of Hire Employee’s Date of Birth

*aproximadamente* (time/*a la(s) hora(s*)) *el* (date/*fecha)* (*del 20* *. )* (*fecha de empleo*) (*fecha de nacimiento*)

Employee's social security number: Employee’s Home Address:

*Número de seguro social del empleado: Direccion del empleado*

Employee's Telephone Number(s): Home: , Mobile: ,Other: ,

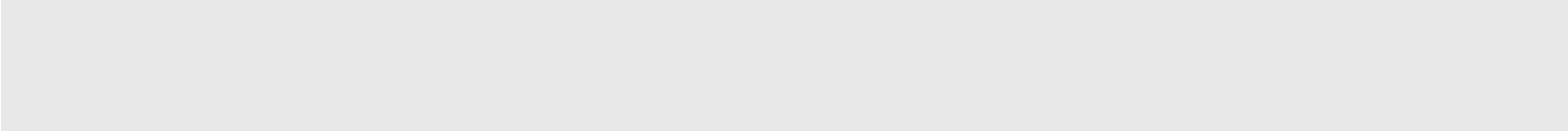
*Número de t e l éfono(s):* (*Casa*) (*Celular*) (*Otro*)

Where did the accident occur?

*¿Dónde ocurrió el accidente?*

What happened?

*¿Qué ocurrió?*



**Worker will choose health care provider. Employer has right to change health care provider after 60 days**

*Trabajador elegirá elproveedor de atención médica. El empleador tiene e l derecho de cambiar el proveedor de atención médica después*

*de 60 dias*

Signed: Signed/Notice Received: *Firma:* (employee/*empleado*) *Firma/Notificación recibida:* (employer or representative/*empleador o representante)* Date/Fecha: Date/*Fecha*:

**ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.**

**PREVIOUS NOA FORMS ARE STILL VALID FOR USE**

**Worker (*Trabajador*)**

For emergency medical care, go to any emergency medical facility. (*Para emergencias médicas vaya a cualquier clinica / hospital.*)

Workers and Employers with questions about workers' compensation may contact an Ombudsman at any New Mexico Workers' Compensation Administration office for information and assistance. The offices are open Monday through Friday, 8 a.m. to 5 p.m., except holidays.

(*Trabajadores y empleadores con preguntas acerca de la compensación de los trabajadores pueden comunicarse con un asesor ("ombudsman") a cualquier oficina de la Administración de la Compensación de los Trabajadores para información y asistencia. Las oficinas están abiertas desde las ocho de la mañana hasta las cinco de la tarde de lunes a viernes, con la excepción de dias festivos.*)

**Statewide Helpline -- *Linea de Asistencia***

**1-866-WORKOMP / 1-866-967-5667**

**toll free *-- llamada sin costo de larga distancia***

**New Mexico Workers' Compensation Administration PO Box 27198, Albuquerque, NM 87125**

|  |  |  |  |
| --- | --- | --- | --- |
| Albuquerque: | (505) 841-6000 - 1 (800) 255-7965 | Las Cruces: (575) 524-6246 - 1 (800) 870-6826 | Santa Fe: (505) 476-7381 |
| Farmington: | (505) 599-9746 - 1 (800) 568-7310 | Las Vegas: (505) 454-9251 - 1 (800) 281-7889 |  |
| Hobbs: | (575) 397-3425 - 1 (800) 934-2450 | Roswell: (575) 623-3997 - 1(866) 311-8587 |  |

**Employer/employee: Each keep one copy.**

***Empleador/empleado: Retener una copia.***

**Form NOA-2- NMPSIA Rev. 11/18**

**Employer Name & Logo Here**

Dear Treating Health Care Provider of our valued employees:

(Employer) values our employees and is concerned for the individual welfare of all employees. In the event of a workplace injury, we want to put injured workers back to work in a safe, productive capacity as soon as possible while they are recovering. By doing so, we seek to contribute to the medical recovery of injured workers by providing meaningful work activities as approved by you, their treating health care provider.

We have a return-to-work program and if one of our employees is unable to return to his/her original job, we will make every attempt to return this employee to modified or light duties. We will also ensure that these duties meet with ALL the medical restrictions that you prescribe and will monitor/support our workers during this process. If necessary, we are willing to rearrange work schedules around diagnostic or treatment appointments.

To assist in this process, we have enclosed for your review:

* The Notice of Accident form describing the incident
* Provider’s Report of Physical Ability

We ask that you fill out the “Provider’s Report of Physical Ability” form after each appointment. **Please give the completed “Provider’s Report of Physical Ability” back to our worker so they may inform us of any work restrictions that we can accommodate**.

Thank you in advance for your assistance in our early return-to-work efforts.

If you have any questions, please contact (company workers’ comp contact) at phone# or by email at .

Sincerely,

**Please route bills to our workers’ compensation TPA:**

CCMSI

PO Box 30870

Albuquerque NM, 87190-0870

Phone: (505) 837-8700

X Company workers’ comp contact

**4 - FOLLOW-UP**



WORKERS’ COMPENSATION

ADMINISTRATION

**PROVIDER'S REPORT OF PHYSICAL ABILITY**

This form shall be reimbursed **if completed at initial visit or for a change in work status or activity restrictions**, per WCA Health Care Provider Fee Schedule p. 22. Helpful guidelines on back

**1 - GENERAL INFORMATION**

**Worker Name** (Last, First) **Date of Injury Facility Address and Phone**

**SSN-last 4 digits**

xxx-xx-

**Visit Type:** Initial Follow-up - **For follow-ups, is there a change in your recommendation since last visit?** YES NO

**Diagnosis:**

In my opinion, this diagnosis is: Work-related Not work-related

**Maximum Medical Improvement (MMI) indications (Check one and indicate date) :**

Worker reached MMI on (date). Not at MMI but anticipated on (date).

**Primary Treating Provider Name**

**Date of Birth**

**Visit date**

**OPTION 1 – Released to regular work**

**OPTION 2 – Not released to ANY work at all**

**OPTION 3 – Released to modified duty**



**2 - WORK STATUS**

**After evaluation, I recommend this worker be (check only one option) :**

Status from (start date): to (end date): Released to hours and tasks routinely performed on the job held at the time of injury. SKIP TO SECTION 4 FOLLOW-UP

Status from (start date): to (end date): The worker is not capable of performing ANY work activities at this time. SKIP TO SECTION 4 FOLLOW-UP

Status from (start date): to (end date): Released to work, **subject to the following restrictions in Section 3 ACTIVITY RESTRICTIONS** (Unmarked items indicate no restriction)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **3 - ACTIVITY RESTRICTIONS** | | | | | | | | | | | | | | | | | | |
|  | **Lift / Carry / Push / Pull Restrictions (if any)** | | | | | | | | | | | | | | | | | |
| **Maximum cumulative hours/day** | | |  |  |  |  |  | **0** |  | **2** | **4** |  | **6** |  | **8** |  | **Other** |
| Lift from the floor **Left Right** | | |  |  |  |  |  | lbs. |  | lbs. |  | lbs. |  | lbs. |  | lbs. |  |
| Lift from waist height **Left Right** | | |  |  |  |  |  | lbs. |  | lbs. |  | lbs. |  | lbs. |  | lbs. |  |
| Carry **Left Right** | | |  |  |  |  |  | lbs. |  | lbs. |  | lbs. |  | lbs. |  | lbs. |  |
| Push **Left Right** | | |  |  |  |  |  | lbs. |  | lbs. |  | lbs. |  | lbs. |  | lbs. |  |
| Pull **Left Right** | | |  |  |  |  |  | lbs. |  | lbs. |  | lbs. |  | lbs. |  | lbs. |  |
| **Posture / Motion Restrictions (if any)** | | | | | | | | | | | **Miscellaneous Restrictions (if any)** | | | | | | |
| **Maximum cumulative hours/day** | | | **0** |  | **2** |  |  | **4** | **6 8** | **Other** | Max hours per day of work: | | | | | | |
| Stand |  | |  | | | | | | |  | Sit/stretch breaks of (# of times) per | | | | | | |
| Walk |  | |  | | | | | | |  | **Medication Restrictions (if any)** | | | | | | |
| Sit |  | |  | | | | | | |  | Meds restrict ability to work safely (explain restrictions below) | | | | | | |
| Bend / Stoop |  | |  | | | | | | |  | **Psychological Restrictions (if any)** | | | | | | |
| Twist |  | |  | | | | | | |  | Psychological restrictions evident (explain restrictions below) | | | | | | |
| Kneel / Squat |  | |  | | | | | | |  | **OTHER RESTRICTIONS / MODIFICATIONS (be specific) :** | | | | | | |
| Climb (stairs/ladder) |  | |  | | | | | | |  |  | | | | | | |
| Drive |  | |  | | | | | | |  |
| Grasp / Squeeze |  | **Left Right** |  | | | | | | |  |
| Wrist (flex/extension) | **Left Right** | |  | | | | | | |  |
| Fine manipulation | **Left Right** | |  | | | | | | |  |
| Reach above shoulder | **Left Right** | |  | | | | | | |  |
| Reach below shoulder | **Left Right** | |  | | | | | | |  |
| Other: | | |  | | | | | | |  |

|  |  |
| --- | --- |
|  | **Expected follow-up services (check all that apply and indicate dates, if known) :**  Next evaluation by treating provider on (date) at (time)  Referral to / Consult with (provider name and specialty)  Physical / Occupational therapy / Chiropractic / Osteopathic Rehabilitation / Reconditioning x/week for weeks  Other treatment / Follow-up  Worker fully discharged from care. This is the last scheduled visit for this problem. |
| **Provider Signature**: Date this form completed: | |

Rev 1/202

|  |  |
| --- | --- |
| **WCA PROVIDER'S REPORT OF PHYSICAL ABILITY (back page)** | |
| **HELPFUL GUIDELINES / DEFINITIONS FOR HEALTH CARE PROVIDER (HCP) COMPLETING THIS FORM** | |
| **BASIC INFORMATION:** | |
| * **For questions on this form:** Email the WCA Medical Cost Containment Bureau at [WCA-MCC@state.nm.us](mailto:WCA-MCC@state.nm.us) or call 505-841-6042**.** * **Purpose of this form:** Because a prolonged workplace absence is detrimental to a worker’s well-being, the WCA asks that you facilitate the recovering worker’s safe, efficient return-to-work by providing interested parties a clear, quantitative description of current claim-related physical restrictions. In this way, you help employers identify suitable work and assign safe work activities. * **When / who fills this form out:** Based on a reasonable medical probability, you as the primary treating HCP are encouraged to fill this form out at each appointment, however **you can only be reimbursed if the form is completed at the initial assessment or if there is a change in work status or activity restrictions**, as indicated in the WCA Health Care Provider fee Schedule and Billing Instructions (HCP Fee Schedule). * **After you fill this report out:** Provide a copy to the worker immediately after each office visit. * Note- This form is not intended to substitute a Functional Capacity Evaluation (FCE). | |
| **DEFINITIONS OF PHYSICAL CAPACITY LEVELS (for reference only):** | |
| **Sedentary -** Ability to lift up to 10 lbs. occasionally or 5 lbs. frequently with sitting, walking/standing necessary to carry out duties  **Light -** Ability to lift up to 20 lbs. occasionally or 10 lbs. frequently, significant standing/walking or sitting with pushing/pulling of arm/leg  **Medium -** Ability to lift up to 50 lbs. occasionally or up to 25 lbs. frequently  **Heavy -** Ability to lift up to 50 lbs. occasionally or up to 50 lbs. frequently | |
| **HELPFUL GUIDELINES:** | |
| **1 - GENERAL INFORMATION** | Fill out worker's name, last 4 digits of SSN, date of birth, date of injury, visit date, your clinic or facility name |
| and address, your name as the primary treating HCP and your phone number   1. Visit Type: Indicate if this is an initial or follow-up visit for this worker regarding this workers' compensation injury/illness 2. For Follow-ups only: Check either YES or NO to indicate if you are making ANY change in recommendation since the last visit 3. Diagnosis: Indicate diagnosis. Underneath, check if, in your opinion the diagnosis is work-related or not work-related. Check only one box 4. Maximum medical improvement (MMI) –Check only one box. Indicate the date if the worker has reached MMI at the current visit or at a   prior visit. If worker is not at MMI yet, write the date you anticipate the worker might reach MMI | |
| **2 - WORK STATUS** | Check the appropriate option box to indicate if the medical condition(s) resulting from this workers' compensation |
| injury/illness will allow for this worker to return-to-work in some capacity. For each option, indicate the start and anticipated end date of your current work status recommendation. If it is permanent, you can write that in. Note: DO NOT check more than one box.   1. Option 1 - Check this box to release the worker to regular work with no restrictions. Do not fill out Section 3 ACTIVITY RESTRICTIONS.   Skip to Section 4 FOLLOW-UP and sign/date   1. Option 2 - Check this box if you recommend NO work at all be performed at this time. Do not fill out Section 3 ACTIVITY RESTRICTIONS.   Skip to Section 4 FOLLOW-UP and sign/date   1. Option 3 - Check this box if you feel the worker can return to work in a modified duty capacity with restrictions. Fill out Section 3 ACTIVITY RESTRICTIONS to indicate all the applicable restrictions as well as Section 4 FOLLOW-UP and sign/date | |
| **3 - ACTIVITY RESTRICTIONS** | Fill this section out only if you checked "Option 3 – Released to modified duty" in Section 2 WORK STATUS |
| * These restrictions are based on the HCP's best understanding of the employee's essential job functions * If a particular restriction does not apply, leave it blank. All unmarked items are considered no restrictions * Note to worker : These restrictions should be followed outside of work as well as at work  1. Lift / Carry / Push / Pull Restrictions: For each activity listed that you are restricting -   a1. Check "Left or "Right" if limitation is to just one side. For bilateral restrictions, check both "Left" AND "Right"  a2. Under the maximum cumulative hours/day allowed, write the maximum number of pounds the worker can handle a3. Under "Other," indicate further instructions beyond the maximum cumulative hours/day allowed, if appropriate  – Note re lifting restrictions: If you are restricting lifting from the floor, indicate If lifting from waist height is also restricted   1. Posture / Motion Restrictions: For each activity listed that you are restricting -   b1. Where applicable, check "Left or "Right" if limitation is to just one side. For bilateral restrictions, check both "Left" AND "Right" b2. Under the maximum cumulative hours/day allowed, write the maximum number of pounds the worker can handle  b3. Under "Other," indicate further instructions beyond the maximum cumulative hours/day allowed, if appropriate   1. Miscellaneous Restrictions: Check all restrictions that may apply and write in applicable specifics 2. Medication Restrictions: Check if medication(s) restrict work ability. Explain restrictions under "Other restrictions/modifications" 3. Psychological Restrictions: Check if psychological factors restrict work ability. Explain under "Other restrictions/modifications" 4. Other Restrictions / Modifications: If your recommendations are not indicated anywhere else on this form, write in | |
| **4 - FOLLOW-UP** | Fill this section out at each appointment to indicate ongoing treatment / follow-up services / referrals |
| you are recommending. Check all that apply and indicate dates, if known   1. Next evaluation: Provide the date of the next scheduled appointment the worker has with you as the treating provider 2. Referral to / Consult with: If you are referring the worker to a specialist or other HCP, write in the HCP name and specialty 3. Physical / Occupational Therapy: Circle appropriate treatment and indicate how many times per week worker should attend 4. Other Treatment / Follow-up: Check if applicable. Write in any other treatment and/or follow-up you are recommending 5. Worker fully discharged: Check only if you are discharging the worker from any further care for this particular condition Rev 1/202 | |

**Optum**

PO Box 152539

Tampa, FL 33684-2539

**MAKING IT EASY...**

# TO GET WORKERS’ COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers’ compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

**Injured Employee:**

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers’ compensation claim is accepted, you will receive a more permanent pharmacy card in the mail.

Please use that card for other work-related injury or illness prescriptions.

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

**Questions? Need Help?**

 **1-866-599-5426**



**WORKERS’ COMPENSATION PRESCRIPTION DRUG PROGRAM**

CCMSI

CARRIER/TPA

EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

**Notice to Cardholder:** Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

**Attention Pharmacists:** Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

**Tmesys Pharmacy Help Desk 1-800-964-2531**

RxBIN

RxPCN GROUP

NDC 004261

CAL

CCMSIH01

Envoy

or 002538

or Envoy Acct. #

***NOTE:*** *This First Fill card is only valid for your workers’ compensation injury or illness.*

**Employer:**

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Com- pensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as “Optum.”



IMP14-1614-109-FFWG

**Employer Name & Logo Here**

INTERNAL Workers Compensation First Report of Injury

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EMPLOYER:** | | | | | **CONTACT:** | | | | | | | **CARRIER / FEIN: 850365634** | | | | | **CLAIMS ADMINISTRATOR:** | | | |
|  | | | | |  | | | | | | | NMPSIA  (New Mexico Public Ins. Authority)  410 Old Taos Hwy. Santa Fe, NM 87501 | | | | | CCMSI  (Cannon Cochran Management Services Inc.)  P.O. Box 30870  Albuquerque, NM 87190-0870  Tel 505-837-8700 / 1-800-635-0679 | | | |
| **OCCURANCE OF INCIDENT AND WORK DATES** | | | | | | | | | | | | | | | | | | | | |
| *Date of Incident:* | |  | | *Time Incident Occurred:* | | | | |  | | *Date Last Worked:* | |  | | | *Date Returned to Work:* | | | |  |
| **SPECIFIC LOCATION OF INCIDENT** (School Name, Building, Room Number, hallway, etc.) | | | | | | | | | | | | | **DATE FIRST REPORTED TO EMPLOYER** (MM/DD/YYYY) | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | | | |
| **Is there video surveillance of the incident? If so, please save and send to HR Contact.**  (Describe Injured Employee’s appearance (hair color, glasses, color of shirt, or anything that would identify them in the video at the time of the incident) | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **INJURED EMPLOYEE NAME** | | | | | | | | | | **DATE OF BIRTH**  (MM/DD/YYYY) | | | | **SOCIAL SECURITY NUMBER**  (Full/Complete SSN) | | | | | **GENDER AT BIRTH** | |
| *Last* | | | *First* | | | *Middle* | | | |  | | | |  | | | | | * Male ☐ Female | |
|  | | |  | | |  | | | |
| **Work Email & Phone Number** | | | | | | | **Personal Email & Phone Number** | | | | | | | | **Preferred Language:** | | | | | |
|  | | | | | | |  | | | | | | | |  | | | | | |
| **INJURED EMPLOYEE MAILING ADDRESS** | | | | | | | | **JOB TITLE** | | | | | | | | | **DATE OF HIRE** (MM/DD/YYYY) | | | |
|  | | | | | | | |  | | | | | | | | |  | | | |
| **WAGES/SALARY | $** | | | | | | | | | | | | **EMPLOYMENT STATUS** | | | | | | | | |
| * Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually | | | | | | | | | | | | * Full-Time ☐ Part Time ☐ Hourly ☐ Other | | | | | | | | |
| **EMERGENCY CONTACT FOR INJURED EMPLOYEE** | | | | | | | | | | | | | | | | | | | | |
| *Name* |  | | | | | *Address* | |  | | | | | | | | | | *Phone* |  | |
| **ACCIDENT DESCRIPTION:**  - Included Notice of Accident (NOA) with this form. If NOA is illegible or non-English, provide legible English version here. | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| * ***COMPLETE*** *INCIDENT INVESTIGATION REPORT* * ***IDENTIFY*** *ANY WITNESSES AND HAVE THEM* ***COMPLETE*** *WITNESS STATEMENT* | | | | | | | | | | | | | | | | | | | | |
| **PART(S) OF BODY AFFECTED/ SYMPTOMS:** | | | | | | | | | | | | **TYPE OF ACCIDENT** (e.g. Fall, Strain, etc.) | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | |
| **TREATMENT RECEIVED *OR* PLAN TO RECEIVE** | | | | | | | | | | | | | | | | | | | | |
| * None ☐ First Aid Only (by self, staff nurse, etc.) ☐ Physician/Health Care Provider ☐ Hospital ☐ Emergency Room/Urgent Care ☐ Transported | | | | | | | | | | | | | | | | | | | | |
| **PREPARER’S NAME AND PHONE NUMBER** | | | | | | | | | | | | **DATE SUPERVISOR or ADMINISTRATOR NOTIFIED** (MM/DD/YYYY) | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | |
| **EMPLOYEE’S SIGNATURE AND DATE** | | | | | | | | | | | | **SUPERVISOR or ADMINISTRATOR SIGNATURE AND DATE** | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | |

**FOR OFFICE USE ONLY**



**INCIDENT INVESTIGATION REPORT**

|  |  |  |
| --- | --- | --- |
| Date of injury: | Time of injury: | Date and time of investigation: |
| **WHO** was injured: | | |
| **WHO** else was involved in the incident: | | |
| **WHO** witnessed the incident: | | |
| **WHAT** was the employee doing when injured? | | |
| **WHAT** equipment, process or activity not described above may be related to the incident? | | |
| **WHERE** did the incident take place? | | |
| **WHAT** is the specific injury? (include body part(s) and severity) | | |

- Continued on back –

|  |
| --- |
| **WHY** did this injury occur to this person at this time? Describe immediate cause and all underlying (root) causes you can identify. Continue to ask "why" for at least 5 levels of identified causes.  **1.**  **2.**  **3.**  **4.**  **5.** |
| **HOW** can similar incidents be prevented in the future? (include management, employee, equipment and environmental considerations) |
| Name and title of investigator: |
| Signature: |
| **Safety Committee Follow-up:** What preventive measures were put in place to permanently avoid recurrence of similar incidents? |