

**PACIFIC WESTERN DISTRIBUTORS ASSOCIATION
EMPLOYEE ACCIDENT INVESTIGATION REPORT
(CONFIDENTIAL)**

STORE NO.: _____ DATE OF REPORT: _____ DATE OF ACCIDENT/INJURY: _____ TIME: _____ AM / PM

INFORMATION ABOUT THE EMPLOYEE

NAME: _____ SS #: _____ EE #: _____ M: _____ F: _____

ADDRESS: _____
NO. & STREET CITY STATE ZIP

PHONE NO.: _____ BIRTHDATE: _____ DATE OF HIRE: _____ JOB TITLE: _____

COST CENTER: _____ (HOURLY) WAGES: _____

STATUS: FULL TIME _____ PART TIME _____ TEMPORARY _____ SCHEDULED NO. HOURS PER WEEK: _____

EMPLOYEE RETURNED TO WORK? YES ___ NO ___ EMPLOYEE PAID FULL WAGES FOR DATE OF INJURY? YES ___ NO ___

INDEMNITY CLAIM (MORE THAN 72 HOURS OF TIME LOST)? YES ___ NO ___

INFORMATION ABOUT CARE

NAME OF HEALTH CARE PROFESSIONAL: _____

NAME OF FACILITY: _____

ADDRESS: _____
NO. & STREET CITY STATE ZIP

WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? _____ WERE THEY HOSPITALIZED OVERNIGHT? _____

WAS THE TREATMENT FIRST AID? _____ CASE NUMBER FROM OSHA 300 LOG: _____

WHAT PART OF THE BODY WAS HURT? DESCRIBE THE INJURY: _____

INFORMATION ABOUT THE INCIDENT

WHAT WAS THE EMPLOYEE DOING WHEN INJURED?: _____

HOW AND WHERE DID THE ACCIDENT OCCUR? _____

WHAT WAS PRIMARY CAUSE OF THE ACCIDENT? _____

WHO WITNESSED THE ACCIDENT/INJURY? (OBTAIN WRITTEN STATEMENTS AND ATTACH) _____

WHAT ACTIONS HAVE/WILL BE TAKEN TO PREVENT REOCCURRENCE? _____

IF THE ACCIDENT WAS CAUSED BY A HAZARD ON THE PREMISES, WAS THIS HAZARD CORRECTED IMMEDIATELY? IF NOT, WHEN WILL IT BE CORRECTED? _____

WAS ACCIDENT CAUSED BY AN UNSAFE ACT? _____ DISCIPLINARY ACTION TAKEN _____

DO YOU RECOMMEND FURTHER INVESTIGATION OF THIS CLAIM? WHY? _____

REPORT TAKEN BY: _____ TITLE: _____

STORE MANAGER SIGNATURE: _____

*PLEASE COMPLETE ALL ITEMS IMMEDIATELY AND FAX TO CORPORATE. LOG INFORMATION ON 300 FORM AND FILE IN STORE.
(INFORMATION IN THIS FORM IS CONFIDENTIAL)*