



Employee Injury or Illness Notification

The **employee** and any witness must complete and sign the *Employee Injury or Illness Notification*. The employee's supervisor must complete the *Employer Investigation Report* and then sign, date and return the form to Human Resources within 24 hours. For questions on how to complete this form, contact the HR office at (515) 573-1148. **The employee must also immediately contact Company Nurse at 1-888-770-0928 to report the injury / illness.**

Employee Information (please print)

Name: _____

Address: _____ City: _____

Zip Code: _____ Phone: () _____ Date of birth: _____

Sex: _____ Occupation: _____ Length of Employment: _____

Accident Information

Date / time reported to work (on day of injury): _____ at _____ AM / PM

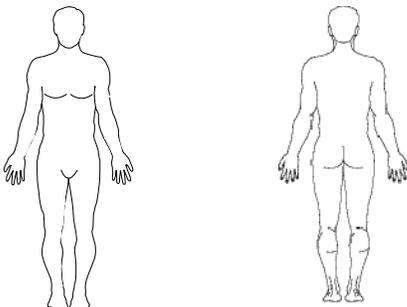
Date and time of injury: _____ Date and time injury reported: _____

How did the accident happen? (please describe in detail)

To whom did you report the accident? (list names)

Who was present when the accident occurred? (list names)

Indicate the injured parts of your body (indicate R or L):



Have you ever injured this part of your body before? YES NO

If yes, please describe: _____

Employer Investigation Report

Employee Information

Employee name: _____

Department/occupation: _____

Date/time of injury: _____

Location of incident: _____

New employee? Yes No

If yes, number of months employed: _____ months

Was employee new to this type of job? Yes No

Was employee trained? Yes No If no, why not? _____

Was employee at fault? Yes No If yes, how? _____

Did the accident involve?

Horseplay Inattention Poor judgment Unauthorized operation

Explain: _____

Procedure

Was there a procedure associated with the task being performed at the time of the accident?

Yes No

If yes, was it being followed correctly: Yes No (explain) _____

Did the procedure fail to prevent the accident? Yes No (if yes, explain how) _____

Investigation

Do you think this was a preventable accident? Yes No Unknown

Was the job properly staffed? Yes No Unknown

Was the job properly supervised? Yes No Unknown

Have similar accidents occurred in the past? Yes No Unknown

Explain / comment: _____

Was first aid given? Yes No

If yes, by whom? _____

Was the employee sent to a medical facility? Yes No

Corporate Health clinic, ER or other? _____

Did the incident occur because of an unsafe act or unsafe condition of equipment? Yes No

If yes, explain:

Was there corrective action taken to prevent accident from happening again? Yes No

If yes, explain:

Supervisor's Signature

Date

**Please send completed form to Human Resources within 24 hours of incident.*

DATE REVIEWED BY SAFETY COMMITTEE: _____