DynamicHR
Total Human Resource Administration

ACCIDENT INVESTIGATION REPORT (Please Print Clearly)

Internal Use Only Date Received: _____
Claim sent to ( ) WC Insurance Carrier date: _____ ( ) Mailed ( ) Telephoned

Claim Number: _____ W/C Contact: _____ Initials: _____

IMPORTANT! If a workplace injury or illness is reported to you, immediately refer the injured employee to the pre-designated medical clinic. All incidents, regardless of severity, must be reported to DynamicHR within 24 hours. Please complete this form and fax it to DynamicHR at 248-370-0968.

THERE ARE STRICT TIME PERIODS IN WHICH ALL CLAIMS MUST BE REPORTED. LATE REPORTING MAY RESULT IN FINANCIAL PENALTIES IMPOSED BY THE STATE.

Employee Information:

Employee: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status: Married ☐ Single/Divorced ☐ Number of Dependents: _____

Does the injured employee speak English? Yes ☐ No ☐

Date of Birth: _____/_____/_____ Date of Hire: _____/_____/_____

Job Title: _____ Hours Worked in Average Day: _____ Days Worked in Average Week: _____

Worksite Employer Information:

Temporary Service Agency: PCMI Address 140 KENT ST. PORTLAND, MI 48875

Worksite Employer Name: _____ Worksite Employer Contact: _____

Worksite Employer Contact Phone: _____ Cell: _____

Accident Information:

Date of incident/accident/injury/illness: _____/_____/_____ Date reported to Dynamic: _____/_____/_____

Time Employee Began Work on Date of Incident: _____ AM PM Time of Incident: _____ AM PM

Address where the accident/injury/illness occurred: _____

County where the accident/injury/illness occurred: _____

Describe the injury or illness (i.e. cut on hand, fractured finger, object in eye): _____

Part of body directly injured (i.e. back, **left** wrist, **right** eye): _____

Has the employee died? ☐ Yes ☐ No If yes, date of death: _____

Did the employee receive medical treatment? No ☐ Yes ☐

If yes, where? _____ Contact Name: _____

Address: _____ Phone: _____

Did the employee miss any work? Yes ☐ No ☐ Last day employee worked: _____

Has the employee returned to work? Yes ☐ No ☐ Date employee returned to work: _____

Was the employee performing their normal job duties when the incident occurred? No ☐ Yes ☐

What was the employee doing before the incident? _____

_____

Incident Description _____

_____

How did the incident occur? (Please describe fully the events that resulted in the incident / exposure. Describe what happened, how it happened and anything about the scene that may have contributed to the incident occurring. Attached additional sheet if necessary)

_____

_____

_____

_____

Name of witnesses to incident / exposure (First and Last name and telephone numbers):

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Do you question the validity of the claim of injury/illness? No ☐ Yes ☐ If yes, why?: _____

_____

_____

Additional Comments:

_____

_____

_____

Completed by: _____ Phone: _____ Date: _____