Employer Investigation Report

The *Employer Investigation Report* must be completed and returned to IMWCA as soon as possible after the incident.

Employee name: ____

Department/occupation: ____

Date/time of injury: ____

Location of incident: ____

How did the incident occur?

____
____
____

Was first aid given? YES NO
If yes, by whom? ____

Was the employee sent to a medical facility? YES NO
If yes, give the name and address:

____

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:

____
____

List names and occupations of witnesses:
Name: __________________________________ Occupation: ______________________________
Name: __________________________________ Occupation: ______________________________
Name: __________________________________ Occupation: ______________________________
Name: __________________________________ Occupation: ______________________________
Name: __________________________________ Occupation:______________________________

____
Supervisor's Signature (date signed)

Please fax or e-mail this completed form to: (978) 367-2862 or imwcaclaims@iowaleague.org