ACCIDENT INVESTIGATION REPORT

Injured Worker Name					**S.S.#**	/ /	
Accident Date	/ /	**Time**	**a.m.**	**p.m.**	**Date Reported**	/ /	
Was Accident on work premises? ☐ **Yes;** ☐ **No**		**If not, where?**					
Complete Accident Description:							
What was the employee doing at the time of injury?							
Part(s) of body injured (For example: right forearm):							
Treatment Information							
Was medical treatment sought? ☐ **Yes;** ☐ **No**		**If so, when?**					
Physician/Hospital Name:							
Physician/Hospital Complete Address:							
Physician/Hospital Telephone Number (include area code): / / **ext.**							
Witness(es) to Accident (list names):							
***** Be Sure to Attach Signed AND Dated Witness Statement(s) *****							
Will there be lost time? ☐ **Yes;** ☐ **No**		**If so, how long?**					
Is alternative light duty work available? ☐ **Yes;** ☐ **No** **If so, describe:**							
Investigator's Information							
Name (printed):				**Title:**			
Signature:					**Date:** / /		

Send completed report to: **Mature Services, Inc.**
Attention: Sue Henige
415 S. Portage Path, Akron, OH 44320
Fax: (330) 762-5571, Phone (330) 762-8666, ext. 186
Toll Free: (800) 554-5335, ext. 186 **New: 4/2008**