Service Lloyds
INSURANCE COMPANY, A STOCK COMPANY

# SUPERVISOR'S ACCIDENT/INCIDENT INVESTIGATION

(Should be completed within 24 hours of accident)

1. NAME OF EMPLOYEE:_____

2. DEPARTMENT: _____

3. DATE/LOCATION OF ACCIDENT:_____
   TIME:_____ A.M. P.M. (circle one)

4. WITNESSES: a._____
   b._____

5. BRIEFLY DESCRIBE ACCIDENT AND NATURE OF INJURY:

_____

_____

6. ACCIDENT CAUSES (check all factors)

PHYSICAL CAUSES
___Defective/improper tools or equipment
___Poor housekeeping (trash, slippery floor, etc)
___Unguarded/improperly guarded equipment
___Congested area
___Unstable/Improper piling or acreage
___Improper apparel
___Improper light, ventilation, temp, etc.
___External security doors, window, alarms, etc.
___Other

PERSONAL CAUSES
___ Not Properly Trained/Instructed
___ Failure to use personal protective equipment
__ Failure to follow rules or instructions
__ Using improper/defective tools or equipment
___ Horseplay
___ Using improper methods/procedures
___ Operating without authority
___ Physical limitations of work
___ Other (describe) _____

7. SIGNATURES: Prepared By: _____
   (Supervisor)
   Reviewed By: _____
   (Person Responsible for Safety)

   _____
   (Manager)

8. FOLLOW UP: What HAS been done to prevent recurrence of this type accident?
   (Follow up within 30 days of accident, check progress at 30 day intervals until complete.)

_____

_____

SIGNATURES: _____
(Person Responsible for Safety)

_____
(Manager)

Date: _____

NOTE: Record any additional information, diagrams, photos, etc. on reverse side.
(Form furnished by Service Lloyds Insurance Company)

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

**CARRIER'S CLAIM #** _____

# EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

| | | | | | |
|---|---|---|---|---|---|
| 1. Name (Last, First, M.I.) | | 2. Sex F ☐ M ☐ | 15. Date of Injury (m-d-y) - - | 16. Time of Injury : am ☐ pm ☐ | 17. Date Lost Time Began (m-d-y) - - |
| 3. Social Security Number - - | 4. Home Phone ( ) | 5. Date of Birth (m-d-y) - - | 18. Nature of Injury* | 19. Part of Body Injured or Exposed* | |
| 6. Does the Employee Speak English? If No, Specify Language<br>YES ☐ NO ☐ | | | 20. How and Why Injury/Illness Occurred* | | |
| 7. Race White ☐ Black ☐ Asian ☐ | 8. Ethnicity Hispanic ☐ Native American ☐ Other ☐ | | 21. Was employee doing his regular job? YES ☐ NO ☐ | 22. Worksite Location of Injury (stairs, dock, etc.)* | |
| 9. Mailing Address Street or P.O. Box<br>City State Zip Code County | | | 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site<br>Street or P.O. Box County<br>City State Zip Code | | |
| 10. Marital Status<br>Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐ | | | | | |
| 11. Number of Dependent Children | 12. Spouse's Name | | 24. Cause of Injury(fall, tool, machine, etc.)* | | |
| 13. Doctor's Name | | | 25. List Witnesses | | |
| 14. Doctor's Mailing Address (Street or P.O.Box)<br>City State Zip Code | | | 26. Return to work date/or expected (m-d-y) - - | 27. Did employee die? YES ☐ NO ☐ | 28. Supervisor's Name / 29. Date Reported (m-d-y) - - |

| | | | |
|---|---|---|---|
| 30. Date of Hire (m-d-y) - - | 31. Was employee hired or recruited in Texas? YES ☐ NO ☐ | 32. Length of Service in Current Position Months _____ Years _____ | 33. Length of Service in Occupation Months _____ Years _____ |
| 34. Employee Payroll Classification Code | 35. Occupation of Injured Worker | | |
| 36. Rate of Pay at this Job $_____Hourly $_____Weekly | 37. Full Work Week is: _____ Hours _____ Days | 38. Last Paycheck was: $_____ for ___ Hours or _____ Days | 39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 40. Name and Title of Person Completing Form | | 41. Name of Business | |
| 42. Business Mailing Address and Telephone Number<br>Street or P.O. Box Telephone ( )<br>City State Zip Code | | 43. Business Location (If different from mailing address)<br>Number and Street<br>City State Zip Code | |
| 44. Federal Tax Identification Number | 45. Primary North American Industry Classification System Code: (6 digit) | 46. Specific NAICS Code (6 digit) | 47. Texas Comptroller Taxpayer No. |
| 48. Workers' Compensation Insurance Company | | 49. Policy Number | |

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
**X** _____ Date _____