Supervisor Accident Investigation

NHRMA MUTUAL

A. Injured Employee Data			
Employee Name:		Position:	Personnel Number:
Work Location			
Date of Accident	Time of Accident ☐ a.m. ☐ p.m.	Claim Number (if known)	
Home Telephone	Work Telephone	Other/Cell Number	
Supervisor		Supervisor Telephone Number	

B. Accident Description

1. Where did the accident happen and who was involved? Provide a full description of the surroundings of the location and the individuals involved.

2. What was happening at the time of the accident and why was it taking place?

3. What exactly caused the injury and how did it happen? What were the mechanics, equipment or tools involved?

4. Describe the injury or injuries incurred. What body part and what kind of injury? (Indicate if no injury occurred.)

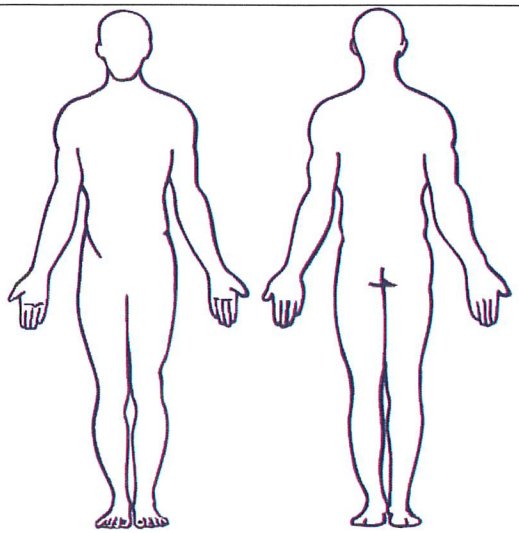
Signature of Supervisor or Accident Investigator	Date	Time ☐ a.m. ☐ p.m.

EMPLOYEE REPORT OF INJURY

FAX IMMEDIATELY OR WITHIN 24 HOURS TO 217.403.4901

NHRMA MUTUAL

Employee Name:	**Place of Employment:**		**Date Hired**
Home Address Street: _____ City: _____ State: _____ Zip: _____ Home Phone #: ( )	**Date of Incident:**	**Reported To:**	**Date Reported:**
	Time of Incident: AM/PM	**Shift at time of injury** 1st 2nd 3rd	Full Time: ☐ Part Time: ☐ Hours per week: _____
	Date of Birth:	**Marital Status:** M S W D	**# Dependents under 18:**
Social Security Number:	**Please describe how you were injured?**		



Using the above drawing, circle any and all areas hurt as a result of the incident

Which part(s) of your body were hurt?
Please include specific detail. (example: left or right; upper or lower)

Previous injury(s) to same body part? Describe (include date of injury)

Who was present when incident occurred?

Do you have any secondary form of employment? If yes, please describe (include name/address of employer):
YES ☐ NO ☐

If yes, is your supervisor here aware of your 2nd job? If yes, supervisor's name:
YES ☐ NO ☐

Are you going to seek medical treatment? ☐ Yes ☐ No
If so, name and address of medical provider?

I agree that the above report is true and accurate

Signature: _____ **Today's Date:** _____

- ALL REPORTS SHOULD BE GIVEN TO YOUR SUPERVISOR IMMEDIATELY AFTER ANY INCIDENT -

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AUTHORIZATION FOR MEDICAL INFORMATION

I hereby authorize any physician, hospital, pharmacy, employer or other person or organization possessing non-medical and medical information to permit NHRMA Mutual or it's representatives to view, copy, be given details of all such non-medical and medical information including drug, alcohol or psychiatric treatment and/or testing. I also agree that any and all of my health care providers may discuss the details of my medical information with the representatives of NHRMA Mutual. This authorization shall remain valid unless revoked in writing with notice to NHRMA Mutual. Upon representation of this authorization or photocopy of it, I give permission for personal review or photocopying of the information by any representative of NHRMA Mutual.

THIS IS NOT A RELEASE OF CLAIM FOR DAMAGES

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Patients Signature **Date**